

FOR STATE HEALTH DEPT.

03997

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03996

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
c. LENGTH OF STAY IN TB DOA		d. STREET ADDRESS 725 Chillum Heights Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank Benjamin Abernathy		4. DATE OF DEATH Month Day Year 3 3 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-11
9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR Months Days Hours Min. 16-1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maiden N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George P. Abernathy		14. MOTHER'S MAIDEN NAME Bertha Mae Cloninger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Geo. Abernathy 1207 Dalewood Dr. S11. Spg.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary atelectasis 527.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) and bronchial aspiration (c) and cirrhosis of liver with fatty changes INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 3-5-67	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial	23b. DATE THEREOF 3-6-67	23c. NAME OF CEMETERY OR CREMATORY Hickory Grove Church	23d. LOCATION (City or Town) (County) (State) Gaston N. C.
24. FUNERAL DIRECTOR Robert E. Wilhelm 4308 Suitland Rd. Suitland Md.		25a. REC'D BY REGISTRAR DATE MAR 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03998

CERTIFICATE OF DEATH

03997

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7514 Dover Lane		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beall Meade (Hyattsville) d. STREET ADDRESS 4300 75th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle L. Last Adams, Jr.		4. DATE OF DEATH Month March Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1897
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. U.S.A.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov.	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry L. Adams, Sr/		14. MOTHER'S MAIDEN NAME Badcock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name, or unknown) (If yes give war dates of service) Yes W.W. I		16. SOCIAL SECURITY NO. W.W. I	
17. INFORMANT Mary P. Adams (Same as # 2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Arteriosclerotic renal vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 446X (b) over 6 mo. (c) over 6 mo.		INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1953 , to 3-8- , 1967, that (I) (we) last saw the deceased alive on 3-8- , 1967, and that death occurred at 5:00am from causes and on the date stated above.			
22a. SIGNATURE John Kehoe, M.D.		22b. DATE SIGNED 3-8-67	
22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D.		22d. ADDRESS 6300 Riverdale Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gansch's Sons		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Hyattsville, Md.		DATE MAR 13 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal at any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03999

03998

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 3108 Craiglawn Road	
3. NAME OF DECEASED (Type or print) Barry T Adkins		4. DATE OF DEATH 3 23 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1951
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Minn		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Arthur Adkins		14. MOTHER'S MAIDEN NAME Betty Schorev	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Arthur Adkins		Address Same as 2 D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO Compound occipital skull fracture (b) Multiple fractures of left leg DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian struck by car.	
20c. TIME OF INJURY Month, Day, Year 9:22pm 3-23-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3700 block Powder Mill Rd., Beltsville, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-24-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3,24.67	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	23d. LOCATION (City or Town) (County) (State) Washington D C
24. FUNERAL DIRECTOR ADDRESS Lee Funeral Home 300.4th st N E		25a. REC'D BY REGISTRAR MAR 27 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04000

CERTIFICATE OF DEATH

03999

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 18 hrs.35mins		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General HOSpital		d. STREET ADDRESS 1122-52nd St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last George W. Ammon		4. DATE OF DEATH Month Day Year March 21, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/8/85
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		11b. KIND OF BUSINESS OR INDUSTRY Construction	
12. BIRTHPLACE (County & State, or foreign country) Washington D. C.		13. CITIZEN OF WHAT COUNTRY? U S A	
14. FATHER'S NAME George Ammon		15. MOTHER'S MAIDEN NAME Annie Dant	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		17. SOCIAL SECURITY NO. Emily E Payne	
18. INFORMANT Bladensburg, Md.		19. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1992 IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung and Liver DUE TO (b) primary unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 20, 1967 , to March 21, 1967 , that (I) (we) last saw the deceased alive on March 21, 1967 , and that death occurred at 5:30xx from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED March 22, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 24, 1967	
23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR Hyattsville, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 28 1967	

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Prince George

Prince George

in the vicinity of

Prince George

Prince George (British Columbia)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04001

CERTIFICATE OF DEATH

04000

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr 45 mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital			d. STREET ADDRESS 829 Booker Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Archie			4. DATE OF DEATH Month Day Year March 9, 19 67		
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1967		9. AGE (In years last birthday) yrs. 1 IF UNDER 1 YEAR Months Days Hours Min. 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pr. Geo. Co., Md.	
13. FATHER'S NAME Michael L. Archie			14. MOTHER'S MAIDEN NAME Jacquelyn Elizabeth Taylor		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7625 Natural Atelectasis IMMEDIATE CAUSE (a) DUE TO prematurity 600 gms. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 9, 1967 , to March 9, 1967 , that (I) (we) last saw the deceased alive on March 9, 1967 , and that death occurred at 10:40 , from causes and on the date stated above.					
22a. SIGNATURE Albert I. Robins			22b. DATE SIGNED 3/10/67		22c. PHYSICIAN'S NAME (Type) Albert I. Robins, M.D.
22d. ADDRESS 1330 New Hampshire Ave. NW, Wash. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/18/67		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp Cheverly PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin.		25a. REC'D BY REGISTRAR MAR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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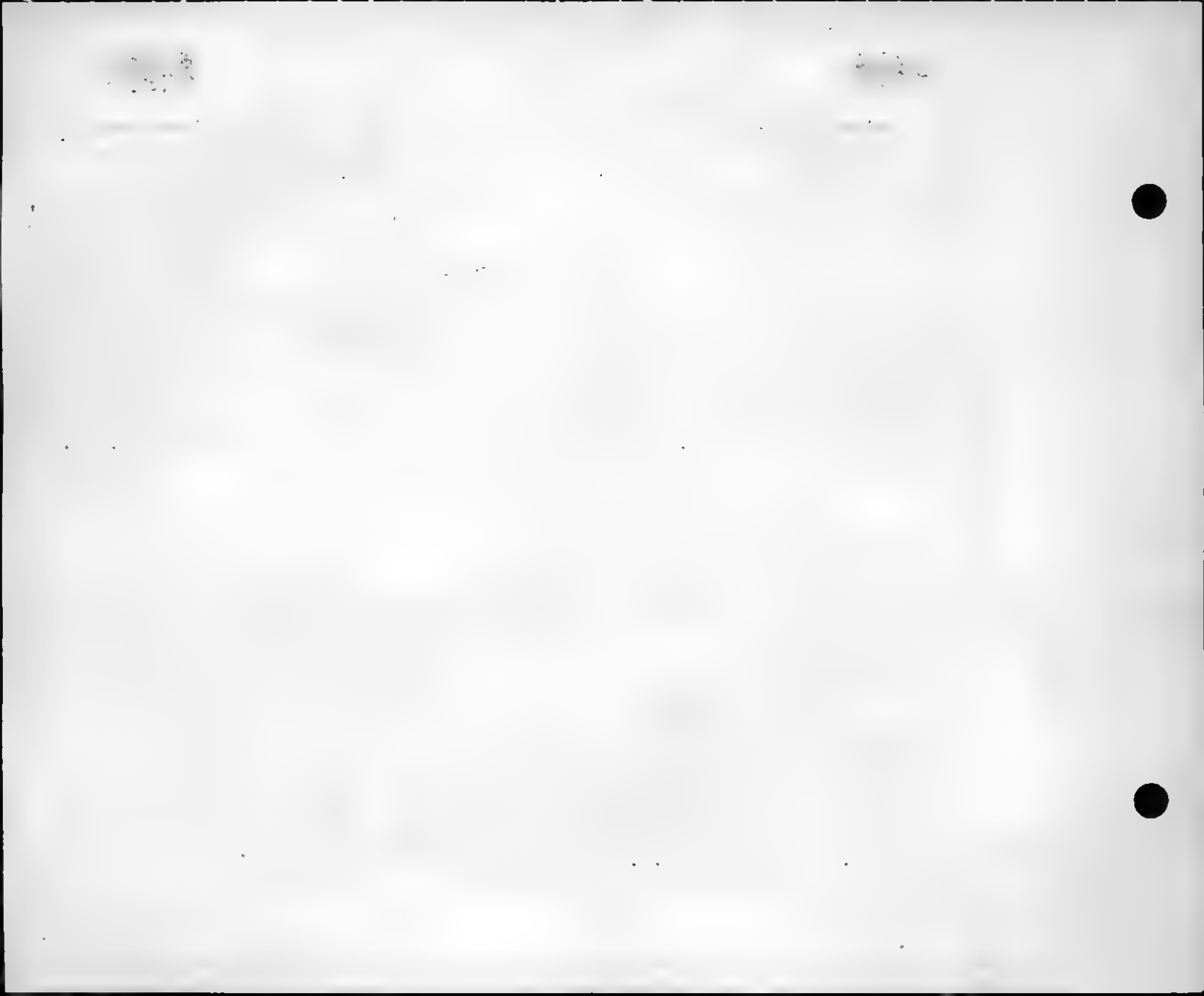
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04002

CERTIFICATE OF DEATH

04001

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Carrollton	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d STREET ADDRESS 8217 Quentin Street	
3 NAME OF DECEASED (Type or print) First Sarah Middle E Last Aukerman		4. DATE OF DEATH Month March Day 21 Year 19 67	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 21 June 1885
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME George Coleman		14. MOTHER'S MAIDEN NAME Mary Campbell	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 194 26 1779	
17 INFORMANT Emma Jane Mc Quown		Address New Carrollton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 8-21-67 , 19 67 , that (I) (we) last saw the deceased alive on 8-20-67 , 19 67 , and that death occurred at 8,508A M, from causes and on the date stated above			
22a SIGNATURE Dr. John A Kehoe, M.D.		22b. DATE SIGNED 3-22-67	
22c PHYSICIAN'S NAME (Type) Dr. John A Kehoe, M.D.		22d. ADDRESS Riverdale, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Mar 23, 1967	23c NAME OF CEMETERY OR CREMATORY United Brethern Cemetery	23d LOCATION (City or Town) (County) (State) Lycippus Pa
24 FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR DATE MAR 28 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04003

CERTIFICATE OF DEATH

04002

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3137 75th Avenue		d. STREET ADDRESS 3137 75th Avenue	
3. NAME OF DECEASED (Type or print) VICTOR COLLINS BALDERSON		4. DATE OF DEATH March 11 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 23 1914
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Oil Heaters	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Blake Balderson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-07-7536	
17. INFORMANT MRS EVA L. BALDERSON		Address Wife (2d)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung DUE TO CARCINOMA LARYNX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 yr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from art , 19 66 , to 3-11 , 19 67 , that (I) (we) last saw the deceased alive on 3-11 , 19 67 and that death occurred at 5:00 M, from causes and on the date stated above.			
22a. SIGNATURE Leonard Hays		22b. DATE SIGNED 3-11-67	
22c. PHYSICIAN'S NAME (Type) LEONARD HAYS		22d. ADDRESS 5201 Blake Cr Hyattsville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 15, 1967	23c. NAME OF CEMETERY OR CREMATORY Rappahannock Ch Cem	23d. LOCATION (City or Town) (County) (State) Newland Va
24. FUNERAL DIRECTOR Lee Funeral Home, 300 4th St NE, Wash.		25. REC'D BY REGISTRAR Mar 14 1967	
25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04004

CERTIFICATE OF DEATH

04003

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forestville</u>		c. LENGTH OF STAY IN It <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing Home</u>		e. STREET ADDRESS <u>7502 Gateway Blvd.</u>	
3 NAME OF DECEASED (Type or print) <u>PEARL</u> First <u>Pearl</u> Middle <u>Evne</u> Last <u>Bass</u>		4 DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1967</u>	
5 SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/6/1911</u>
9 AGE (In years last birthday) <u>55</u> Yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Land Lord</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>ILL.</u>	
12 BIRTHPLACE (County & State, or foreign country) <u>ILL.</u>		13 CITIZEN OF WHAT COUNTRY? <u>ILL.</u>	
13. FATHER'S NAME <u>Charles W. Griesemer</u>		14. MOTHER'S MAIDEN NAME <u>Olie McDurman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Marie Ebert</u>		Address <u>209 W. Park St Champaign Ill.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>1310</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Dehydration & Transition</u> DUE TO (c) <u>Carcinoma of bladder & widespread metastasis 7mo</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Draining Fistula from Bladder & Bowel obstruction</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part for Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January 67</u> to <u>March 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 12, 1967</u> and that death occurred at <u>4:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Relvin L Minchin</u>		22b. DATE SIGNED <u>3/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RELVIN L MINCHIN</u>		22d. ADDRESS <u>6600 MARLBORO PINE SE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-18-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calumet Park Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Crown Point Indiana</u>
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u> <u>4308 Suitland Road Suitland Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. John Kehoe, Deputy Med. Exam., Notified and released.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04005											
04004											
1. PLACE OF DEATH a. COUNTY Pr. Geo.						b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park					
c. LENGTH OF STAY IN 1b 3 Yrs.						d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9004 St. Andrews Place					
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						b. COUNTY Pr. Geo.					
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park						d. STREET ADDRESS 9004 St. Andrews Place					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Katharine Kaes Beckwith						4. DATE OF DEATH Mar. 3 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 May 1893		9. AGE (in years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store				11. BIRTHPLACE (County & State, or foreign country) Germany			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Jacob Kaes				14. MOTHER'S MAIDEN NAME Helena Gohres			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577 10 8953A				17. INFORMANT Theodore R. Beckwith			
18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart Failure</i> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Chronic Ischemic Cardiac -</i> DUE TO (c) <i>vascular disease</i>				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <i>1950</i> to <i>FEB 67</i> , that (I) (we) last saw the deceased alive on <i>2/16</i> 1967, and that death occurred at <i>9A</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>U. L. Etienne</i>				22b. DATE SIGNED 3/3/67				22c. PHYSICIAN'S NAME (Type) U. L. ETIENNE			
22d. ADDRESS College Park Md				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment				23b. DATE THEREOF 3/6/67				23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum			
23d. LOCATION (City, town or county) (State) Colmar Manor Md											
24. FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR MAR 7 1967			
25b. REGISTRAR'S SIGNATURE <i>John Kehoe</i>											

jwb

BP

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04006

CERTIFICATE OF DEATH

04005

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days 5 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 2804 Belair Drive	
3. NAME OF DECEASED (Type or print) First Susie Middle F. Last Bedell		4. DATE OF DEATH Month March Day 31 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1875
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House hold		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David S. Brower		14. MOTHER'S MAIDEN NAME Susan M. Robinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 241-84-2808-J	
17. INFORMANT Mrs. Suzie MacClary, Birmingham, Ala.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Acute Myocardial Infarction DUE TO (c) Coronary Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that W (this hospital) attended the deceased from March 27, 1967 , to March 31, 1967 , that W (we) last saw the deceased alive on March 31, 1967 , and that death occurred at 3:02 A from causes and on the date stated above.			
22a. SIGNATURE W. Hernandez, M.D.		22b. DATE SIGNED March 31, 1967	
22c. PHYSICIAN'S NAME (Type) W. Hernandez, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF April 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	23d. LOCATION (City or Town) (County) (State) Brooklyn, New York
24. FUNERAL DIRECTOR Harold S. Wade, Lamar, Md		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

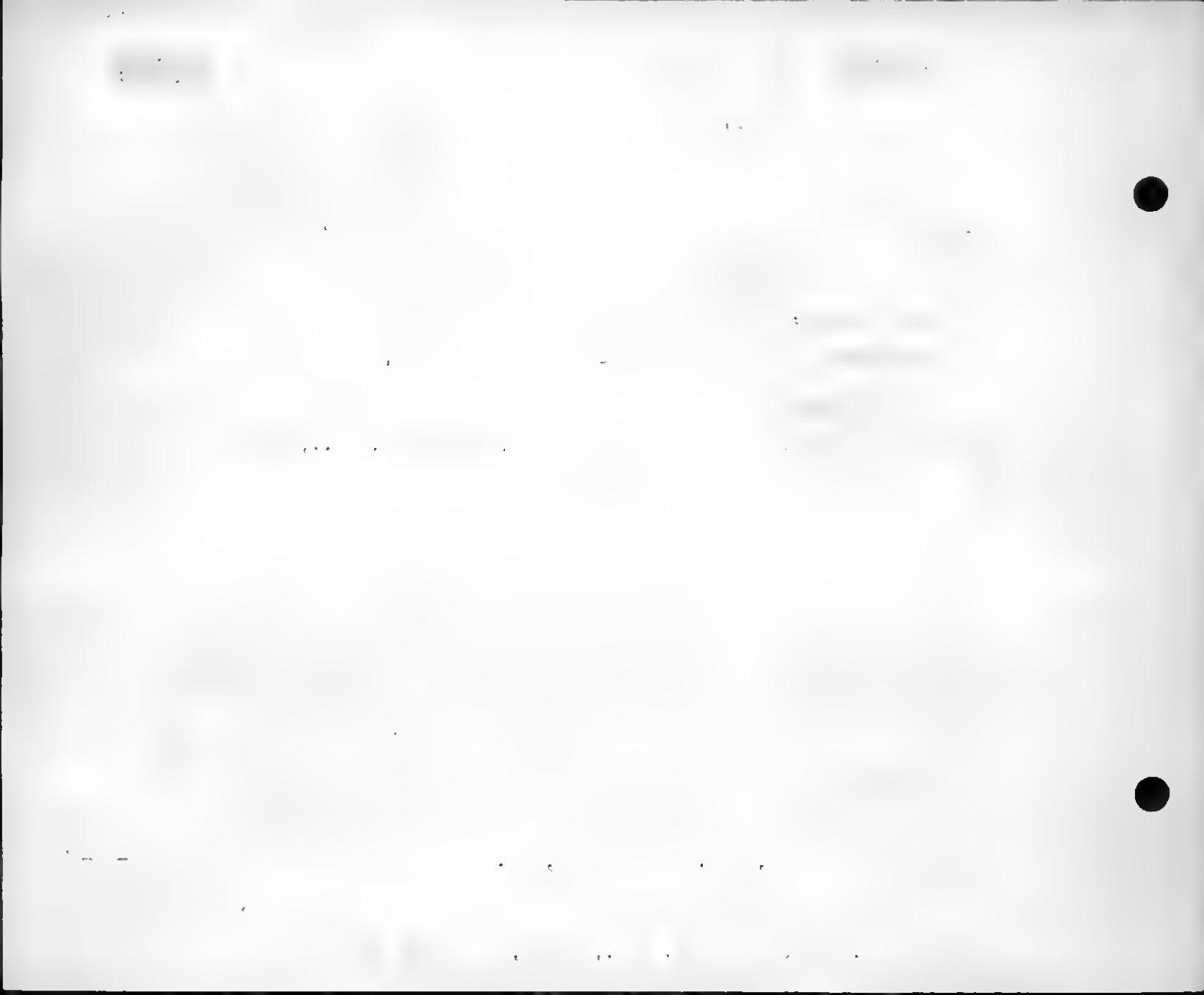
Items 18-21 Film G388 5/18/67 cas

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04007

04006

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b 5 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1100 Main Street		e. STREET ADDRESS 106 Woodlawn Court		f. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Hazel Frances Bell		4. DATE OF DEATH Month Day Year 3 11 1967		5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 13 May 1913		9. AGE (In years last birthday) 53		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) Reanoke, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Lowery		14. MOTHER'S MAIDEN NAME Whipp/ Fannie Witt		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No - - -		16. SOCIAL SECURITY NO. unk	
17. INFORMANT Mr. Stephen H. Bell, Same as #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exposure to cold DUE TO (b) 750.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) - - -		INTERVAL BETWEEN ONSET AND DEATH - - -					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) - - -		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) Froze while sleeping in abandoned building							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 3-6- 1967 p.m. 1100 Main St.		20d. NATURE OF INJURY While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, all care, etc.) 1100 Main St.		20f. (City or town) (County) (State) Laurel, Prince Geo., Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED 3-12-67									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF March 15, 1967		23c. NAME OF CEMETERY OR REPOSITORY Fairview Cemetery,		23d. LOCATION (City or town) (County) (State) Reanoke, Virginia			
24. FUNERAL DIRECTOR Harold S. Wade, 550 Wash. Blvd., Laurel, Maryland		ADDRESS 550 Wash. Blvd., Laurel, Maryland		25a. REC'D BY REGISTRAR MAR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

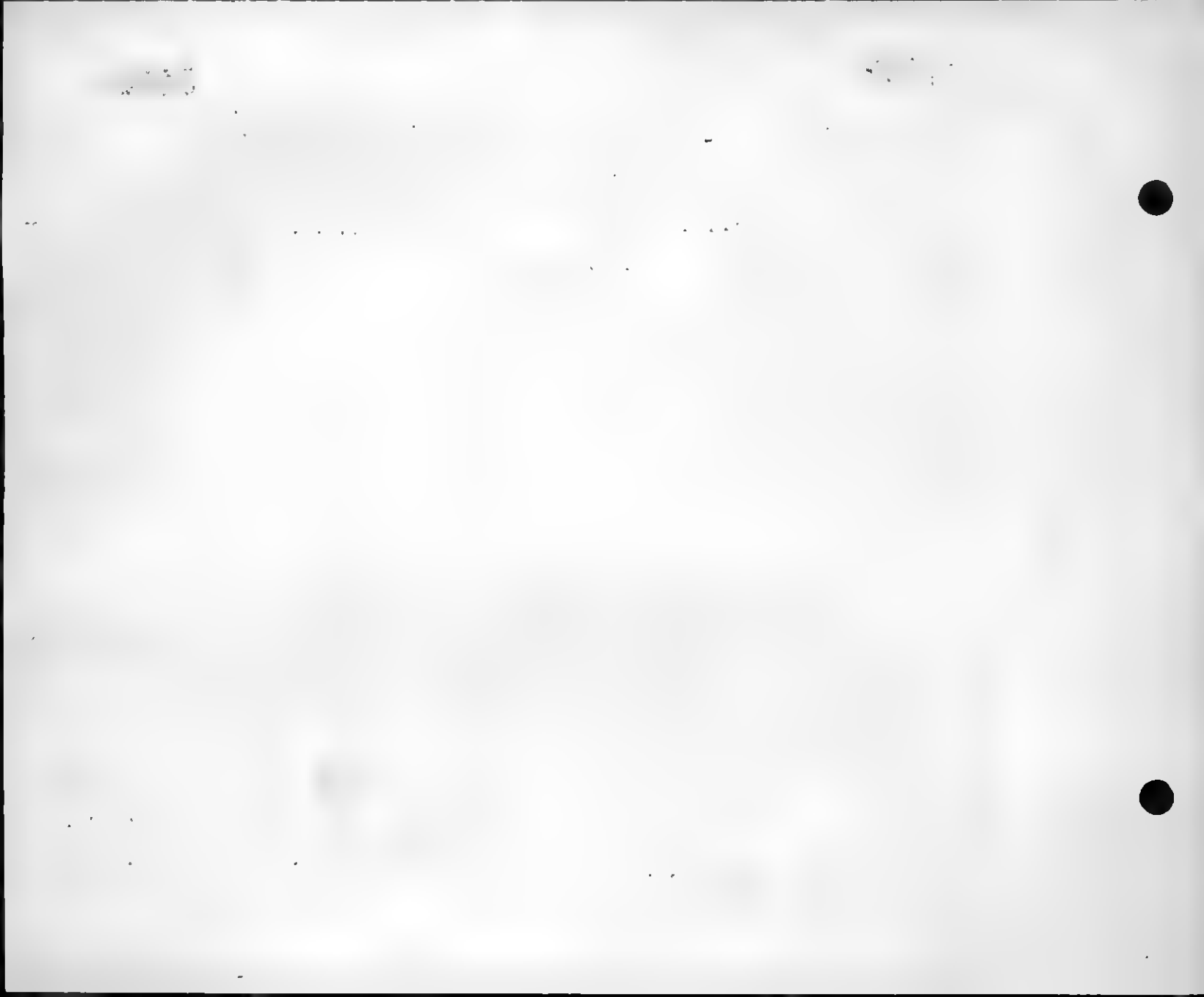
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #3 Film #G388 1/25/67 ps

04008

CERTIFICATE OF DEATH

04007

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 44 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1529-23rd St. S.E.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian Pearl		4. DATE OF DEATH Month March Day 22 Year 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/20/06	
9. AGE (In years lost birthday) yrs 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Eaton		14. MOTHER'S MAIDEN NAME Ella May Polen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lawrence Eaton - Son		Address Bes. Same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Generalized carcinoma DUE TO (b) Carcinoma, st. breast DUE TO (c) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 16 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/6 , 19 67 to 3/22 , 19 67 that (I) (we) last saw the deceased alive on 3/21 , 19 67 and that death occurred at 12:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Julius Kauffman		22b. DATE SIGNED March 22, 1967	
22c. PHYSICIAN'S NAME (Type) Julius Kauffman, M.D.		22d. ADDRESS 6501 Landover Rd. Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-22-67	
23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (City or Town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR Lee Funeral Home. 300 4th. NE, Wash. DC		25a. REC'D BY REGISTRAR MAR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04009

CERTIFICATE OF DEATH

04008

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.		d. STREET ADDRESS 4703 Windom Place, XXXXXX N.W.	
3. NAME OF DECEASED (Type or print) First Henrietta Middle (NMI) Last Berckmann		4. DATE OF DEATH Month March Day 3 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) invalid - none		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John G. Berckmann		14. MOTHER'S MAIDEN NAME Margaret Doyle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 220-44-8701	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malignant Melanoma of Choroid of left eye 1422 DUE TO with generalized metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-10 , 19 43 , to 3-3 , 19 67 , that (I) (we) last saw the deceased alive on 3-3 , 19 67 , and that death occurred at 10:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Collins		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Thomas F. Collins		22d. ADDRESS 322 H St. N. E. Washington, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 6, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR Joseph Gawler's Sons		25a. REC'D BY REGISTRAR MAR 9 1967	
Address Washington, D. C.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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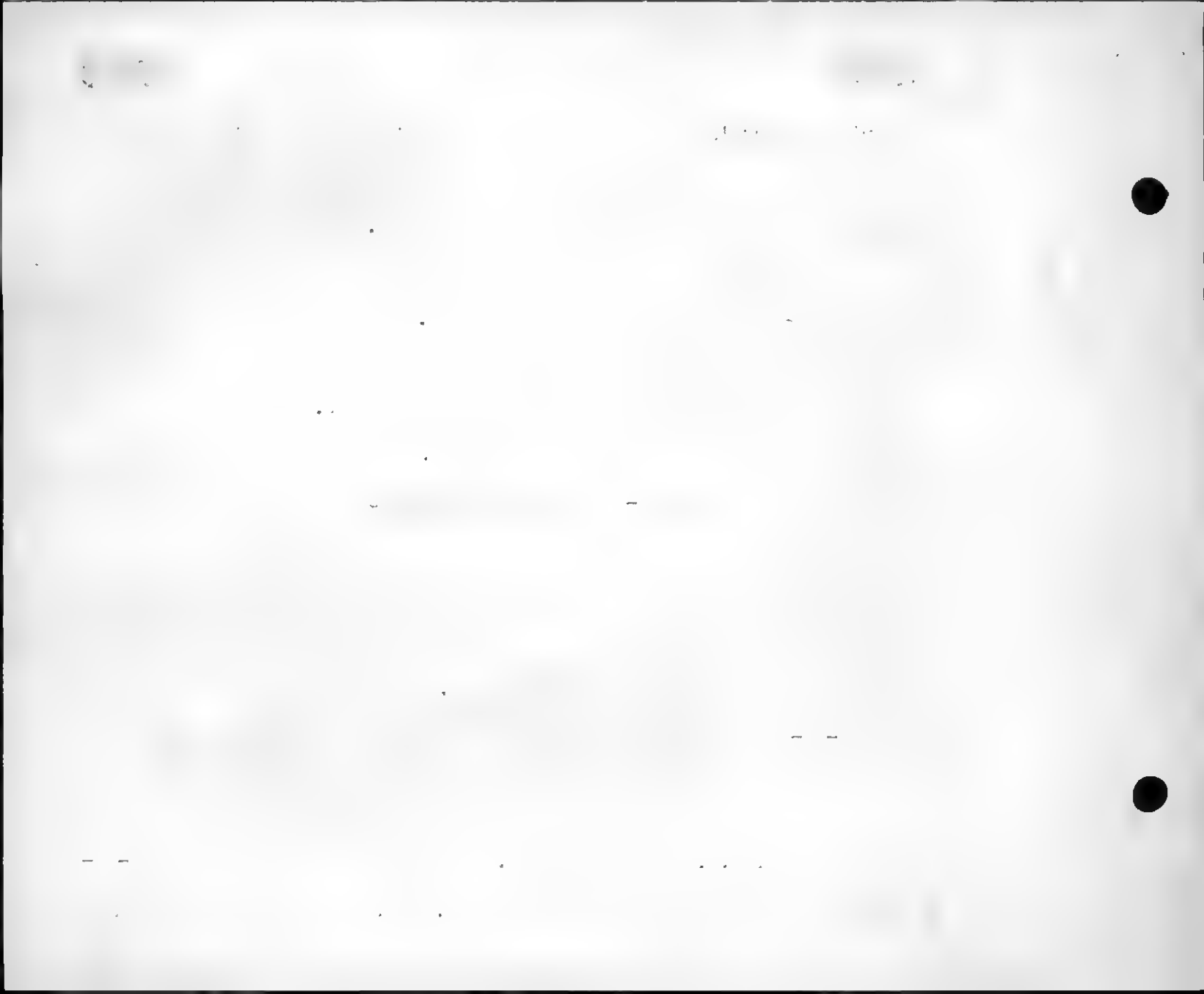
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04009

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o STATE Maryland b. COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN 1b DOA			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d STREET ADDRESS 1152 49th. Avenue			
3 NAME OF DECEASED (Type or print) First Middle Last Mark S Beuchert				4 DATE OF DEATH Month Day Year 3 12 19 67			
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 21 Jan. 1960		9 AGE (In years lost birthday) 7 yrs	10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY?
13 FATHER'S NAME Donald F. Beuchert				14 MOTHER'S MAIDEN NAME Shirley F. Curtin			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16 SOCIAL SECURITY NO		17 INFORMANT Address Donald F. Beuchert Same as Item #2		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Burns - 100 % of body surface 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Burned in house fire.				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9:45pm 3-12- 19 67			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f (City or town) (County) (State) same as #2
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 3-13-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial			23b DATE THEREOF Mar. 15-67		23c NAME OF CEMETERY OR CREMATORY Washington Nat'l. Cem.		23d LOCATION (City or Town) (County) (State) Suitland, Maryland
24 SIGNATURE OF FUNERAL DIRECTOR Simmons Bros.			ADDRESS 1661-Good Hope Rd SE Wash DC		25a REC'D BY REGISTRAR Charles Judge		25b REGISTRAR'S SIGNATURE Charles Judge
					DATE MAR 15 1967		



FOR STATE
HEALTH DEPT

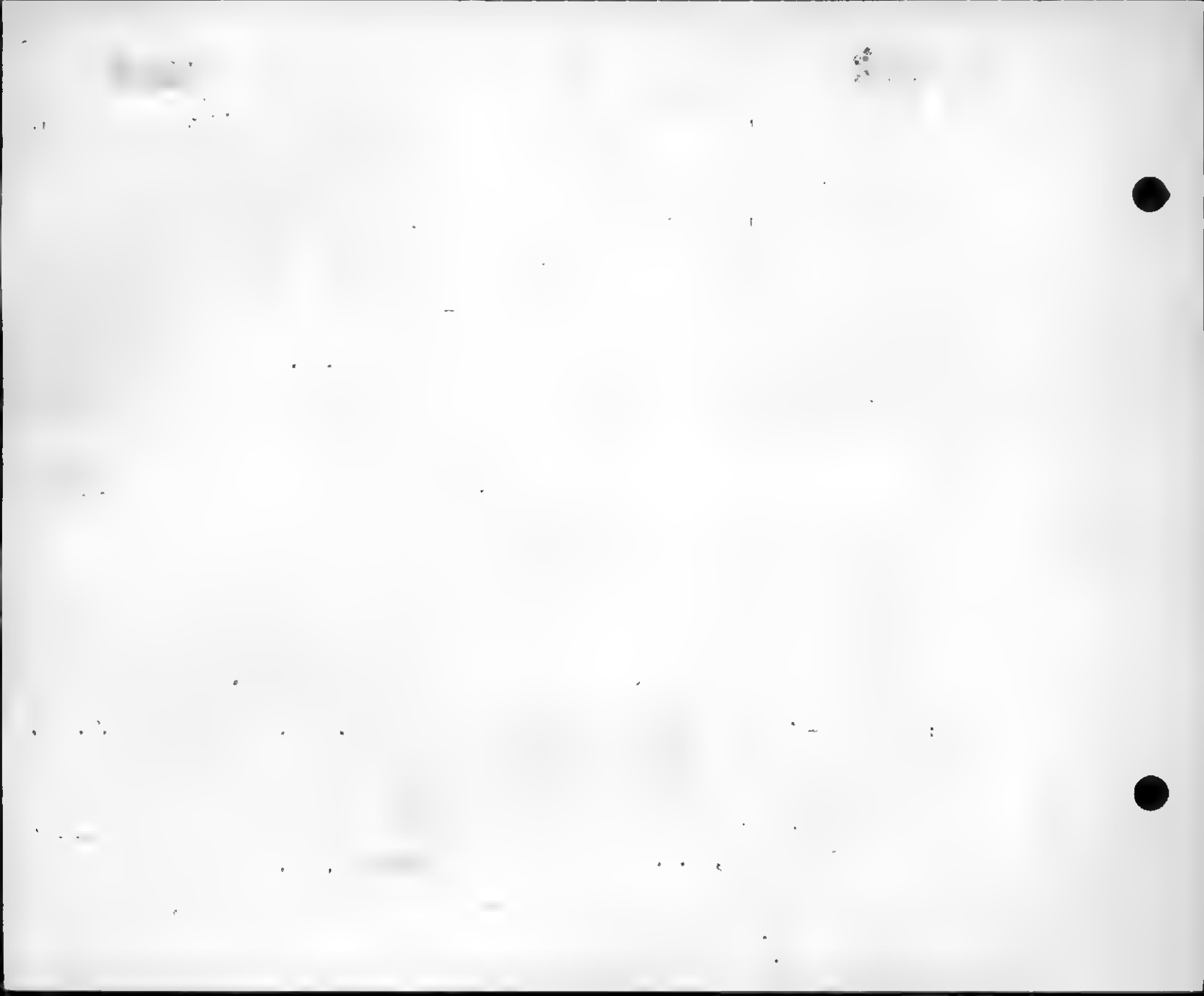
04011

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04010

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY N 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital				e. STREET ADDRESS 5206 Shopton Drive			
3. NAME OF DECEASED (Type or print) First David Middle Jeffrey Last Black				4. DATE OF DEATH Month March Day 31 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-22-49	9. AGE (in years last birthday) 17 yrs	10. F UNDER 1 YEAR Months 31 Days 19 Hours 67 Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Maxwell Henry Black				14. MOTHER'S MAIDEN NAME Christine Lollis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOC. A. SECURITY NO.		17. INFORMANT Christine Lollis Stewart Address Same As # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of chest 9190 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Shot by accidental discharge of rifle.					
20c. TIME OF INJURY Month Day Year 6:55 PM 3-31-67 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 4666 Homer Ave.		20f. (City or town) Apt. B Suitland (County) P.G. Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 4-1-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/4/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or town, County, State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home				25a. REC'D BY REGISTRAR APR 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
4308 Suitland Rd. Suitland Maryland							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05565

CERTIFICATE OF DEATH

05564

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IB 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Old Crain Road Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest August Blank				4. DATE OF DEATH Month March Day 22 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 March 1889		9. AGE (in years last birthday) 78 yrs	IF UNDER 1 YEAR Months Days Hours Mm.	IF UNDER 24 HRS Hours Mm.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood Finisher		10b. KIND OF BUSINESS OR INDUSTRY Employed Building Industry		11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME August C. Blank				14. MOTHER'S MAIDEN NAME Angelica Kushney			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO ----		17. INFORMANT William F. Blank-Cleveland 4, Ohio			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure w/ DUE TO Moderate pulmonary edema, based on Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pneumonic heart disease w/ mitral r (c) arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 12 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office b-dg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 17, 1967 to March 22, 1967 , that (I) (we) last saw the deceased alive on March 22, 1967 , and that death occurred at 4:40AM from causes and on the date stated above							
22a. SIGNATURE Edwin J. Jensen				22b. DATE SIGNED March 22, 1967		22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.	
22d. ADDRESS Prince Georges General Hospital				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/27/67		23c. NAME OF CEMETERY OR CREMATORY Acacia Park Cemetery		23d. LOCATION (City or Town) (County) (State) Mayfield Heights, Ohio	
24. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home-Maryland				25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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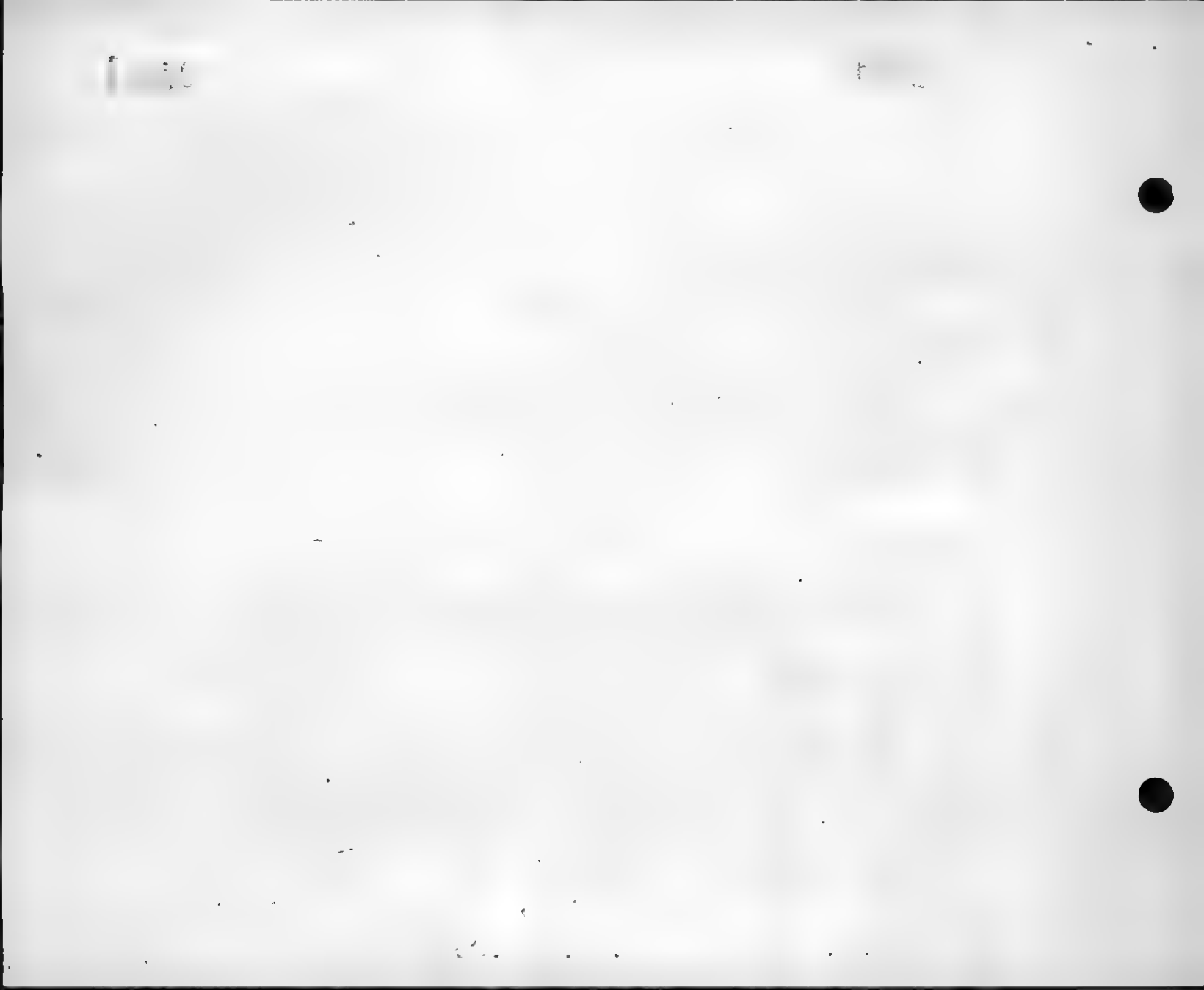
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04012

CERTIFICATE OF DEATH

04011

1 PLACE OF DEATH a. COUNTY <u>PR. GEORGE'S</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON (SIX) DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>So. MARYLAND GEN. HOSP.</u>		d. STREET ADDRESS <u>4751 Hagan Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>ALICE L BOORMAN</u>		4 DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1885</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. gov</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>William H. Adams</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Mc Daniel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Virginia Talbert (Niece) St Barnabas</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Cardiovascular arteriosclerosis</u> DUE TO (c) <u>Hypertensive disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-14, 1967</u> to <u>3-16, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-16, 1967</u> , and that death occurred at <u>10:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin M.D.</u>		22b. DATE SIGNED <u>3-16-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN M.D.</u>		22d. ADDRESS <u>CLINTON, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 20-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill, Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
ADDRESS <u>1661-Gd. Hope Rd. SE. Wash., DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04013

CERTIFICATE OF DEATH

04012

1 PLACE OF DEATH a COUNTY Prince Georges County MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE 2328 25th St. S.E. Wash., D.C. b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton, Md.		c LENGTH OF STAY IN 1b 6 yrs.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pineview Gardens Health Care Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Bossler, Annie M.		4 DATE OF DEATH Month March Day 18 Year 19 67	
5 SEX F	6 COLOR OR RACE Cauc.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/24/81
9 AGE (In years last birthday) 85 86 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Birds Barn, Pennsylvania	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME James Redcay	
14 MOTHER'S MAIDEN NAME Alice McCalicker		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO. n one		17 INFORMANT (Address) Niece Mrs. Brady Bishop 59 31 28th Ave. (Marlow Hts., Md.)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Generalized arteriosclerosis DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, insulin		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) no		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/21 , 19 67 , to 3/18 , 19 67 , that (I) (we) lost saw the deceased alive on 19 , and that death occurred at M , from causes on and on the date stated above.			
22a. SIGNATURE Henry J. Bloen		22b. DATE SIGNED 3/18/67	
22c. PHYSICIAN'S NAME (Type) Dr. Henry Palacios		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-21-67	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN	23d. LOCATION (City or Town) (County) (State) COLMAR MARSH MD.
24 FUNERAL DIRECTOR Lee's Funeral Home 4th & Mass. Ave., N.E.		25a. REC'D BY REGISTRAR MAR 22 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

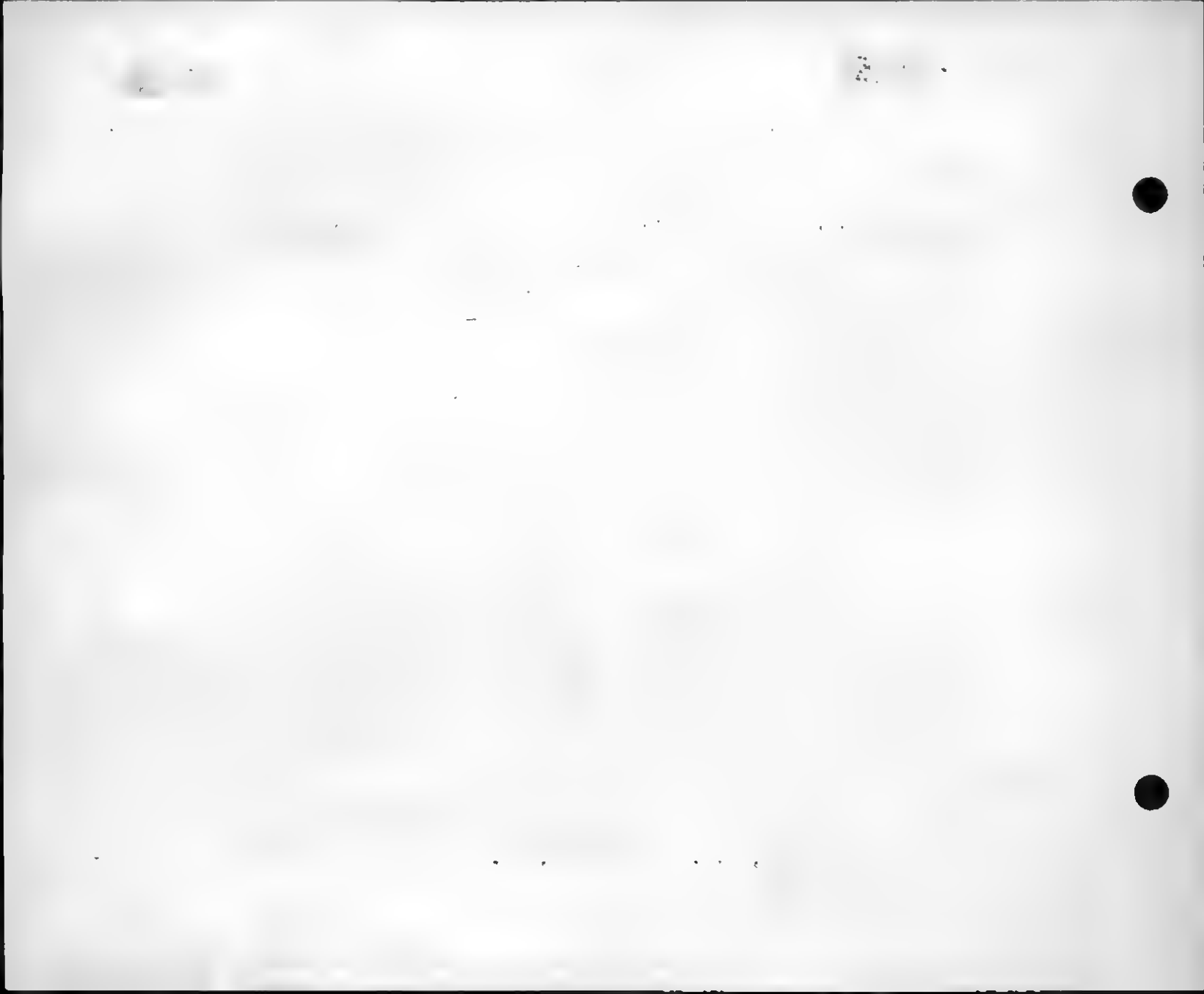
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04014

04013

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN b. DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) William Orthello Bradley				4 DATE OF DEATH 3 7 19 67			
5 SEX Male		6 COLOR OR RACE negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 12-28-1966	
9 AGE (In years last birthday) yrs 2		10 MONTHS 2		11 BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
13 FATHER'S NAME William O. Bradley				14 MOTHER'S MAIDEN NAME Vera Hiers			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16 SOCIAL SECURITY NO None		17 INFORMANT William O. Bradley - Father			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SDII DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22 DATE SIGNED 3-8-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)			
23a. B. R. L. CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-10-67		23c. NAME OF CEMETERY OR CREMATORY Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Southland Md	
24 FUNERAL DIRECTOR H.S. Washington & Sons ADDRESS 4925 Deane Ave N.E.				25a. REC'D BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

6-197999



FOR STATE
HEALTH DEPT.

04016

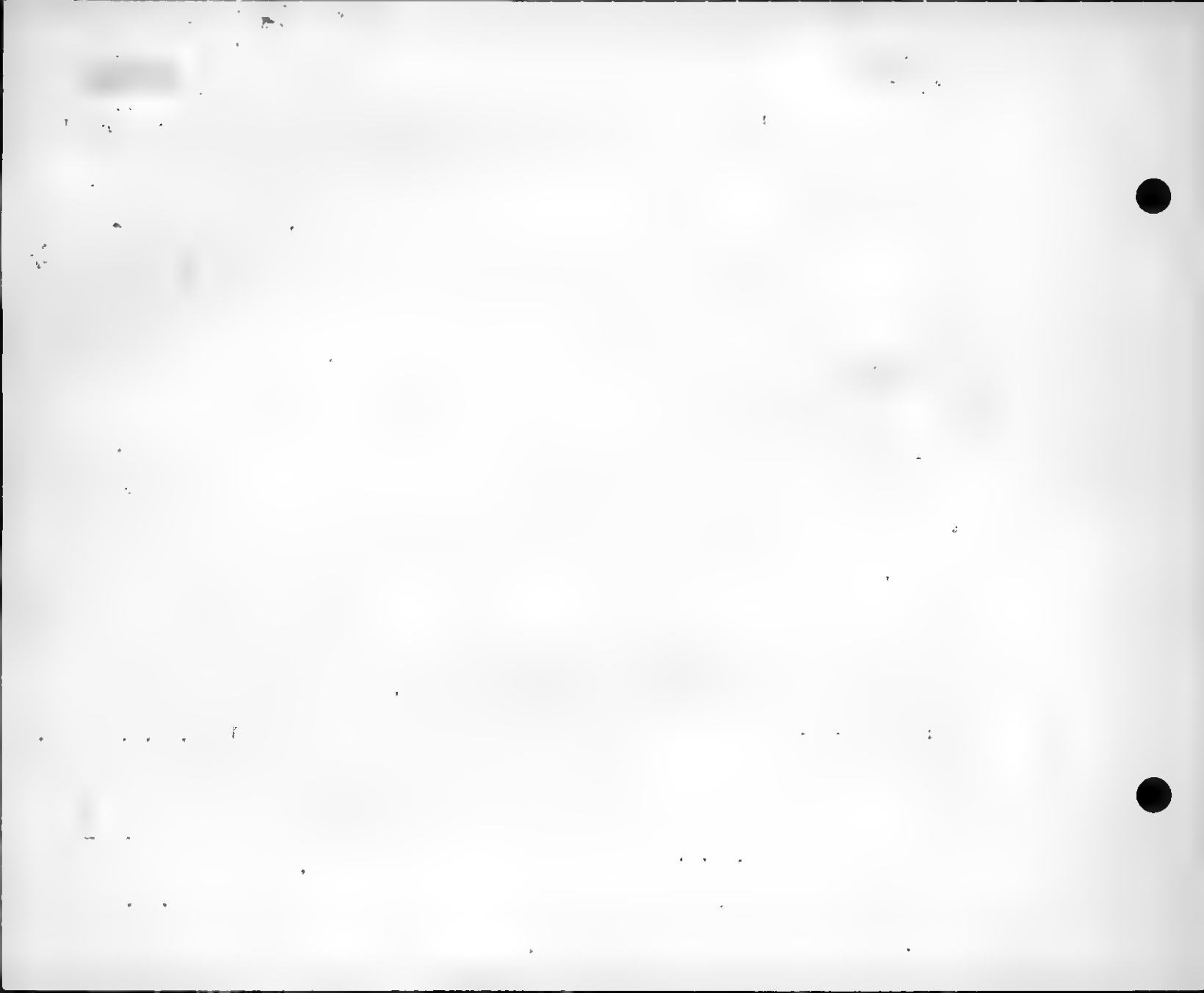
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04014

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) Cheverly		c LENGTH OF STAY N 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d STREET ADDRESS 3233 75th Ave.	
3 NAME OF DECEASED (Type or print) First Middle Last Godfrey Alvin Brower		4 DATE OF DEATH Month Day Year March 10 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 10, 1952
9. AGE (In years last birthday) 14 yrs		10. IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY School	
11 BIRTHPLACE (State or foreign country) Washington D. C.		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Godfrey C Brower		14 MOTHER'S MAIDEN NAME Louise C Mc Cauley	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO none	
17. INFORMANT Godfrey C Brower		Address Landover, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Electrocution DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of the 28) Became entangled in guide wire of radio antenna which touched high-voltage wire.	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 10:41 PM 3-10-67 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home farm factory street office bldg etc) In front of 3385 Dodge Park Rd. P.G. Md.	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 3-11-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street city or county) Riverdale, Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF March 13, 1967	23c NAME OF CEMETERY OR CREMATORY Congressional Cemetery	23d LOCATION (City or town) (County) (State) Washington D. C.
24 FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a REC'D BY REGISTRAR MAR 14 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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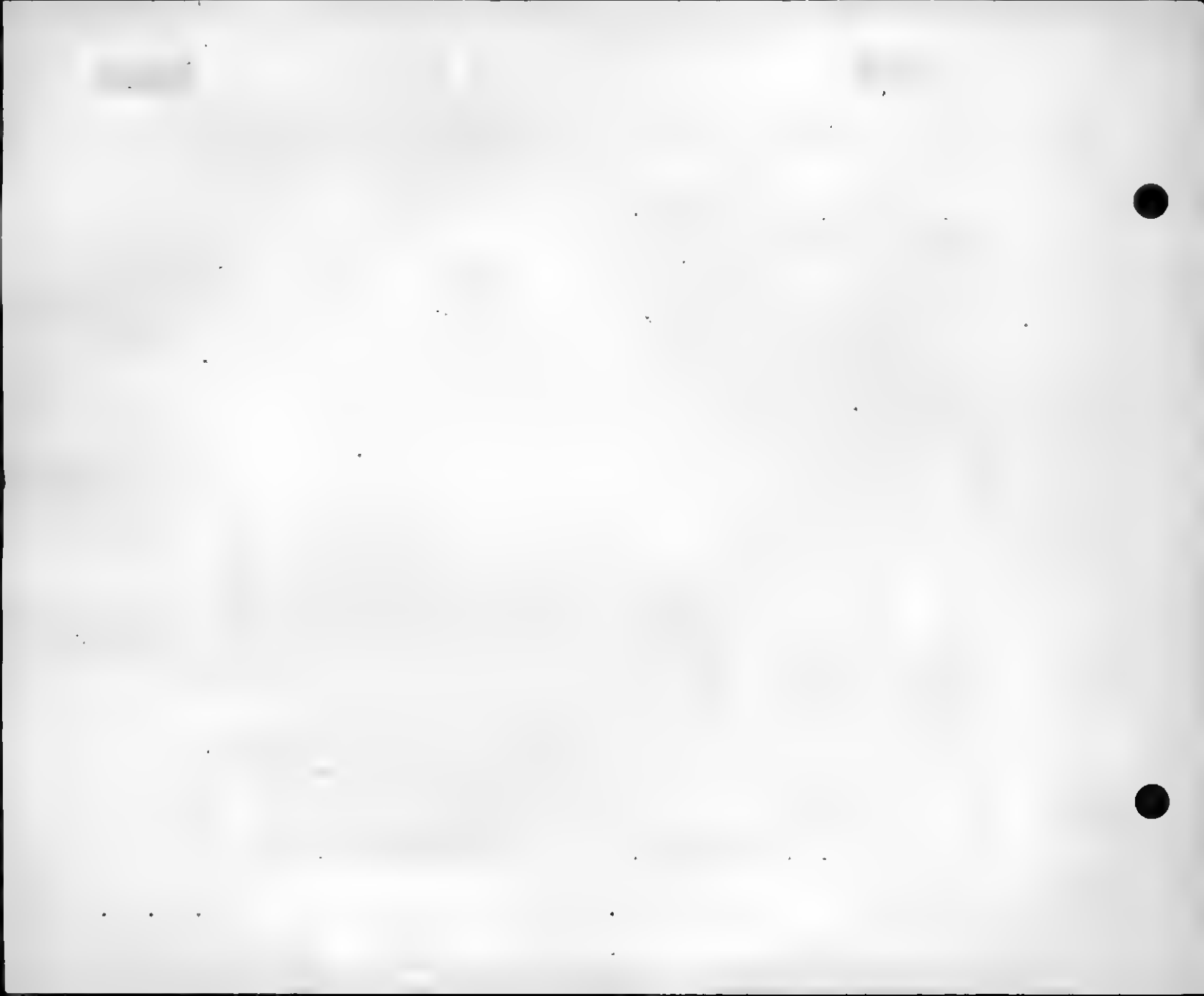
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04015

CERTIFICATE OF DEATH

04015

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB 9 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS Box 388			
3. NAME OF DECEASED (Type or print) First Middle Last Nellie - Brown				4. DATE OF DEATH Month Day Year March 30 1967			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/11/30	
9. AGE (In years lost birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (County & State, or foreign country) Prince George's Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Issac A. Brown				14. MOTHER'S MAIDEN NAME Isabell Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (if yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT Address John Brown Rt. 3-Box 124 Brandywine, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 092 x Chronic Encephalopathy DUE TO long to Infectious Hepatitis (b) Chronic DUE TO 2. th liver secondary (c) to alcoholism							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) to alcoholism							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 21, 1967 , to March 30, 1967 , that (I) (we) last saw the deceased alive on March 30, 1967 , and that death occurred at 9:40AM from causes and on the date stated above.							
22a. SIGNATURE J. A. Garcia				22b. DATE SIGNED 3/31/67		22c. PHYSICIAN'S NAME (Type) J. A. GARCIA, M.D.	
22d. ADDRESS Prince Georges General Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 3/67		23c. NAME OF CEMETERY OR CREMATORY St. Peters Church Cem.		23d. LOCATION (City or Town) (County) (State) Waldorf Chas. Co. Md.	
24. FUNERAL DIRECTOR Martell Adams				25a. REC'D BY REGISTRAR APR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

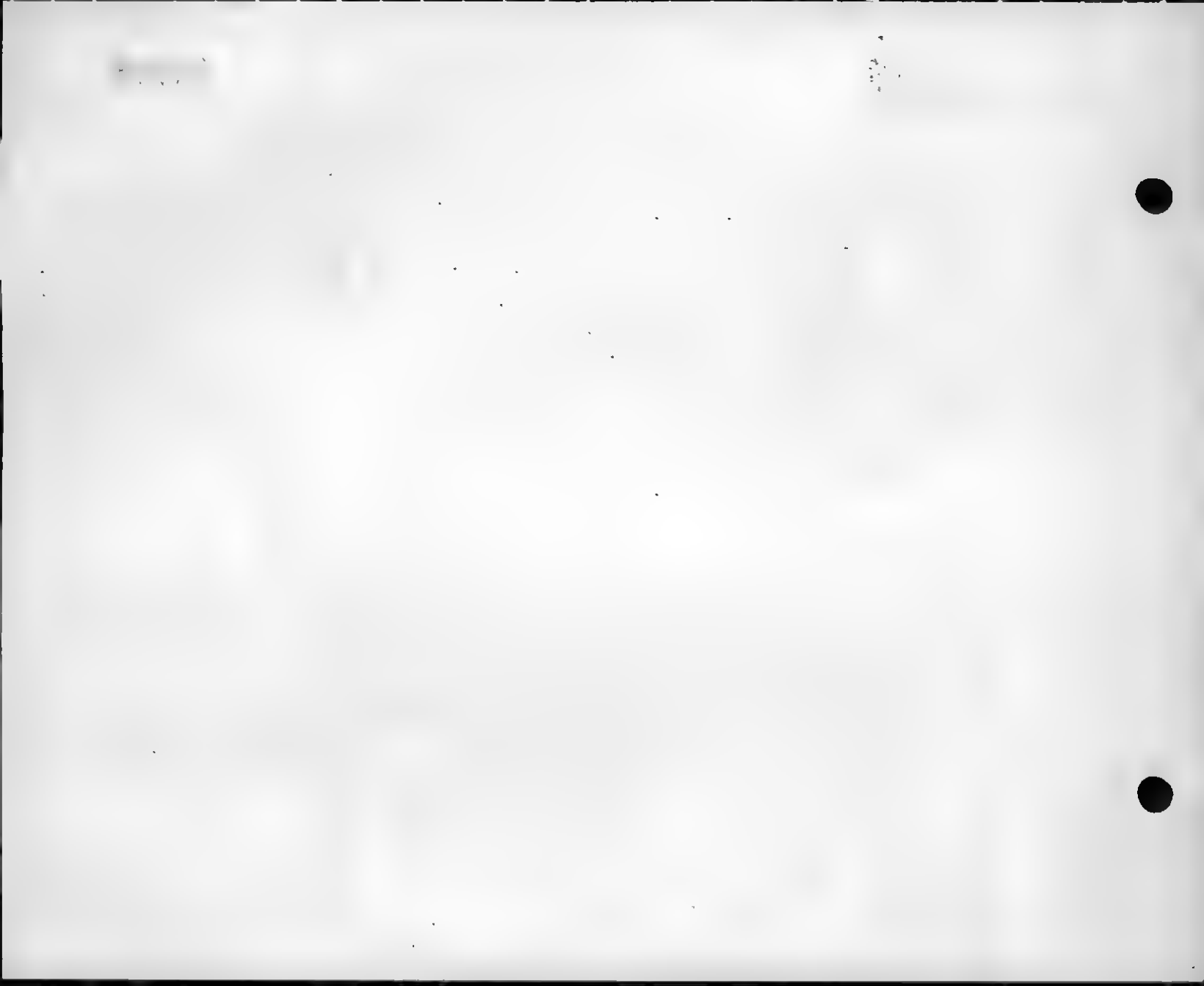
CERTIFICATE OF DEATH

04016

<p>1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u></p> <p>c. LENGTH OF STAY IN 1b <u>8 mo</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Center</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u></p> <p>d. STREET ADDRESS <u>4313 Sheridan St.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		
<p>3. NAME OF DECEASED (Type or print) <u>INEZ</u> First <u>M.</u> Middle <u>BROWNELL</u> Last</p>		<p>4. DATE OF DEATH <u>March</u> Month <u>15</u> Day <u>1967</u> Year</p>		
<p>5. SEX <u>Fe</u></p>	<p>6. CO. OR OR RACE <u>W.</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>June 1 - 1874</u></p>	
<p>9. AGE (in years last birthday) <u>92</u> yrs.</p>	<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>C. Telephone</u></p>	
<p>11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>		
<p>13. FATHER'S NAME <u>Arvin E. Brownell</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Rebecca Gilman</u></p>		
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <u>212-05-0373</u></p>		
<p>17. INFORMANT <u>Lucille P. Wiseman</u> Address <u>Hyattsville Md</u></p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>arteriosclerosis of disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> (c) <u>unstable angina</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>5 yrs.</u> <u>unstable angina</u></p>
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>		
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>	<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> to <u>March 15, 1967</u>, that (I) (we) last saw the deceased alive on <u>Mar 1</u> 19<u>67</u>, and that death occurred at <u>1145</u> M, from causes and on the date stated above.</p>				
<p>22a. SIGNATURE <u>L.W. Malin</u> M.D.</p>		<p>22b. DATE SIGNED <u>Mar 16, 1967</u></p>		
<p>22c. PHYSICIAN'S NAME (Type) <u>L.W. Malin M.D.</u></p>		<p>22d. ADDRESS <u>Riversdale, Md.</u></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE THEREOF <u>March 18, 1967</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u></p>	<p>23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.D. Co Md</u></p>	
<p>24. FUNERAL DIRECTOR <u>F. Sasaki sons Hyattsville Md.</u> ADDRESS</p>		<p>25a. REC'D BY REGISTRAR <u>MAR 20 1967</u></p>		
<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>		<p>25c. REGISTRAR'S NAME</p>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

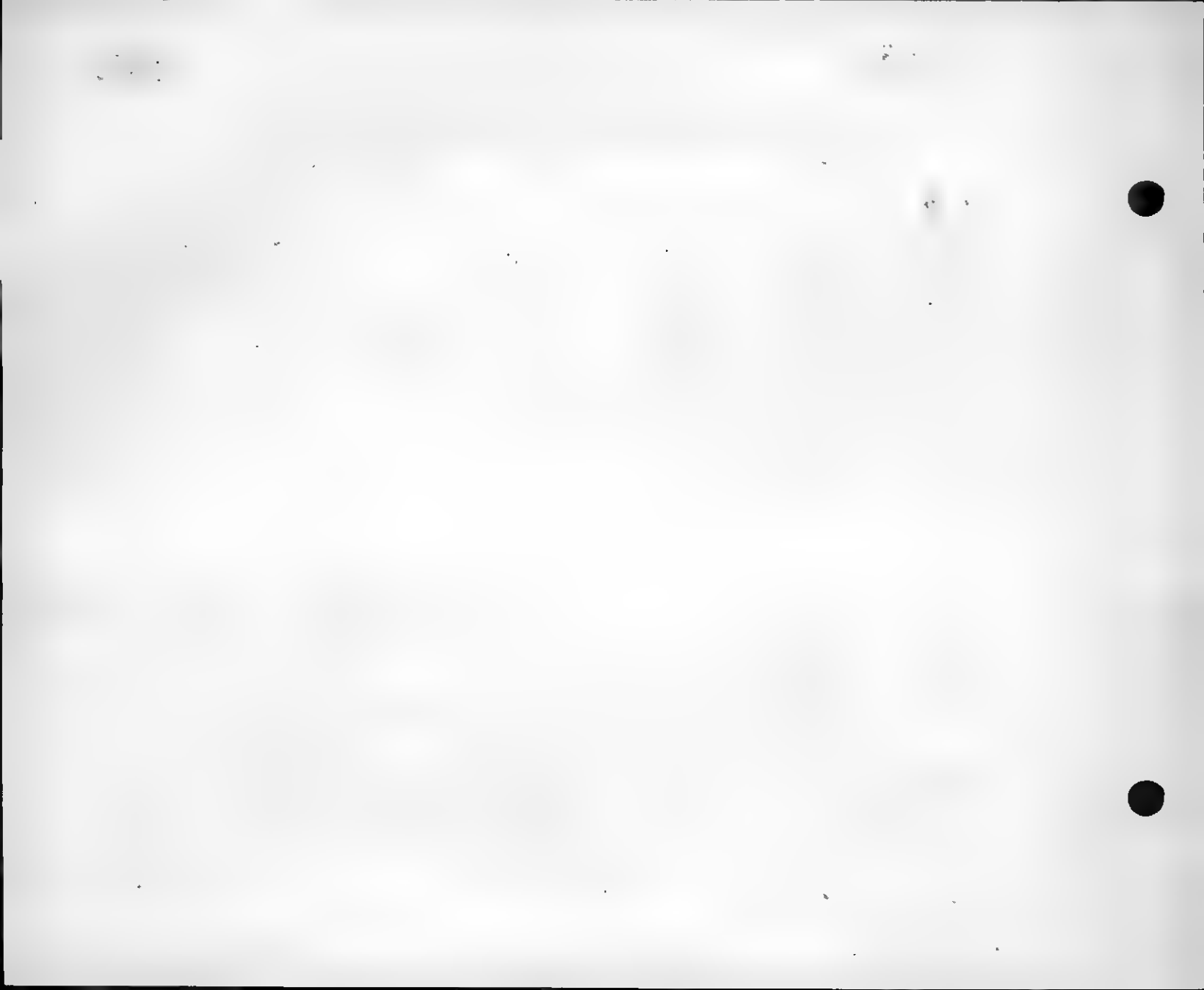
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04018						04017					
1. PLACE OF DEATH a. COUNTY <i>Prince Geo.</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Prince Geo.</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>3925 LIVINGSTON Rd</i>											
3. NAME OF DECEASED (Type or print) <i>ALFRIEDA</i>			First Middle Last <i>ALFRIEDA BRUEHL</i>			4. DATE OF DEATH Month Day Year <i>3/30/67</i> 19			IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <i>FEMALE</i>		6. COLOR OR RACE <i>CAUC</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>OCT 24, 1881</i>		9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>		11. BIRTHPLACE (County & State, or foreign country) <i>SIABRUEK, GERMANY</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>UNK PILGER</i>						14. MOTHER'S MAIDEN NAME <i>UNK</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>REV. FR JOHN QUASTEN, CATHOLIC UNIV. WASH. D.C.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i> DUE TO (b) <i>Arterio sclerosis</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, _____										INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>APR 4</i> , 19 <i>66</i> , to <i>MAR. 30</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>MAR. 26</i> , 19 <i>67</i> , and that death occurred at <i>4:15</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Thomas J. Kelly</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>MAR. 31, 1967</i>		
22c. PHYSICIAN'S NAME (Type) <i>THOMAS J. KELLY, M.D.</i>						22d. ADDRESS <i>6480 N.H. Ave., Takoma Park, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>4/3/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVE</i>		23d. LOCATION (City, town or county) (State) <i>WASH. D.C.</i>			
24. FUNERAL DIRECTOR <i>Will Chambers Co. Riverdale, MD.</i>						ADDRESS		25a. REC'D BY REGISTRAR DATE <i>APR 3 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04019

04018

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DO. b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Forestville			c. LENGTH OF STAY IN 1b 17 Days			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, DO.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Regent Nursing Home				d. STREET ADDRESS 3330- 12th Street SE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) OCIE BUNNER				4. DATE OF DEATH March 18th 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 18th 1887	
9. AGE (in years last birthday) 79 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk		10b. KIND OF BUSINESS OR INDUSTRY Peoples Drug		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles D. Powell			
14. MOTHER'S MAIDEN NAME Margaret Galvin				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO.				17. INFORMANT William H. Bunner (Son) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli DUE TO (b) Cerebral Vascular Thrombosis DUE TO (c) Left hemiplegia, Arterio Sclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-2 , 19 67 , to 3-18 , 19 67 , that (I) was last saw the deceased alive on 3-18 19 67 , and that death occurred at 9-PM , from the causes and on the date stated above.							
22a. SIGNATURE John F. Shay				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 18- 67	
22c. PHYSICIAN'S NAME (Type) John F. Shay				22d. ADDRESS Suitland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 23-1967		23c. NAME OF CEMETERY OR CREMATORY Bluemont Cemetery		23d. LOCATION (City, town or county) (State) Grafton, West Virginia	
24. FUNERAL DIRECTOR Simmons Bros.				ADDRESS 1661-Gd. Hope Rd. SE. Wash., DC		25a. REC'D BY REGISTRAR MAR 21 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

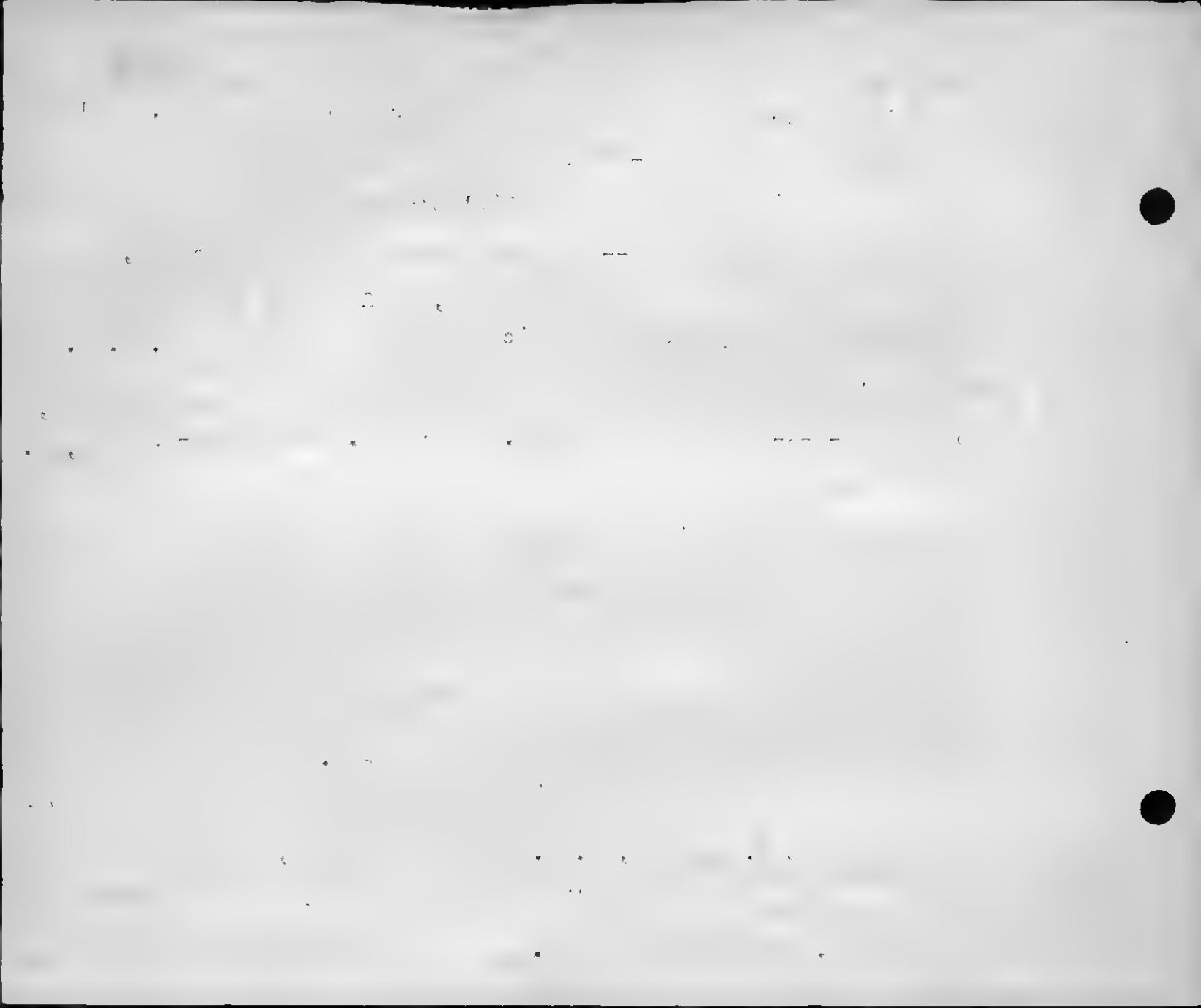
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05577

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>4-Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Adsacorda Nursing Home</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> d. STREET ADDRESS <u>2601 Cheverly Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>--</u> Last <u>Burroughs</u> 4. DATE OF DEATH Month <u>March</u> Day <u>24</u> , Year <u>1967</u>			5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 18, 1872</u> 9. AGE (In years last birthday) <u>94</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Empl'd Clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Nat'l Geographic Magazine</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>John William Burroughs</u> 14. MOTHER'S MAIDEN NAME <u>Mary Posey</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>-----</u> 17. INFORMANT <u>Mrs. Adeline B. Shrewsbury</u> Address <u>RFD Box 2725, Upper Marlboro, Md.</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>Indigestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Interdiction - Generalized severe</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> 20d. INJURY OCCURRED <input type="checkbox"/> White at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>			21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> to <u>24 hrs</u> , that (I) (we) last saw the deceased alive on <u>1967</u> and that death occurred at <u>2:20 A.M.</u> from the causes and on the date stated above.		
22a. SIGNATURE <u>Robert B. Sasscer</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert B. Sasscer, M. D.</u>			22b. DATE SIGNED <u>3/24/67</u> 22d. ADDRESS <u>Upper Marlboro, Maryland 20870</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>3/24/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 23d. LOCATION (City, town or county) (State) <u>Suitland Maryland</u>			24. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Upper Marlboro, Md.</u> 25a. REC'D BY REGISTRAR DATE <u>APR 12 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

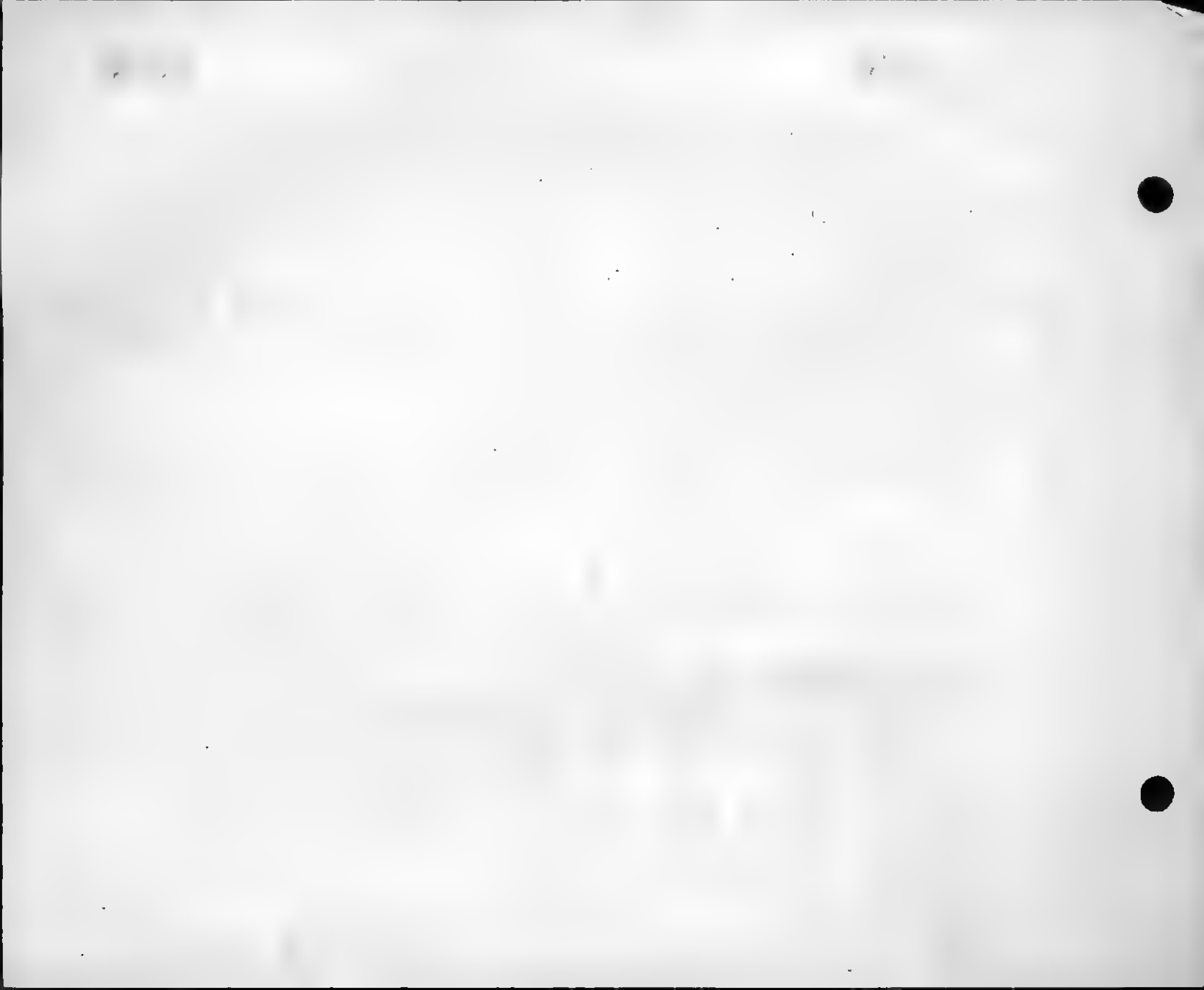
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04020

CERTIFICATE OF DEATH

04019

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Health Care Center</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude K. Burton</u>		d. STREET ADDRESS <u>6561 BOCK TERRACE</u>	
5. SEX <u>F</u>		4. DATE OF DEATH <u>March 15 1967</u>	
6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-28-81</u>		9. AGE (In years last birthday) <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITRESS - RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE CAFETERIA</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID KEARNEY</u>		14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Joseph E. Burton - 6561 Bock Terrace Oxon Hill</u>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 4201 DUE TO <u>Coronary Collapsus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Coronary Insufficiency + Arteriosclerosis</u> (c) <u>Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-3-</u> , 19 <u>67</u> , to <u>3-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-15</u> , 19 <u>67</u> , and that death occurred at <u>4:54 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.		22b. DATE SIGNED <u>3-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>	
ADDRESS <u>Funeral Home</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

04021

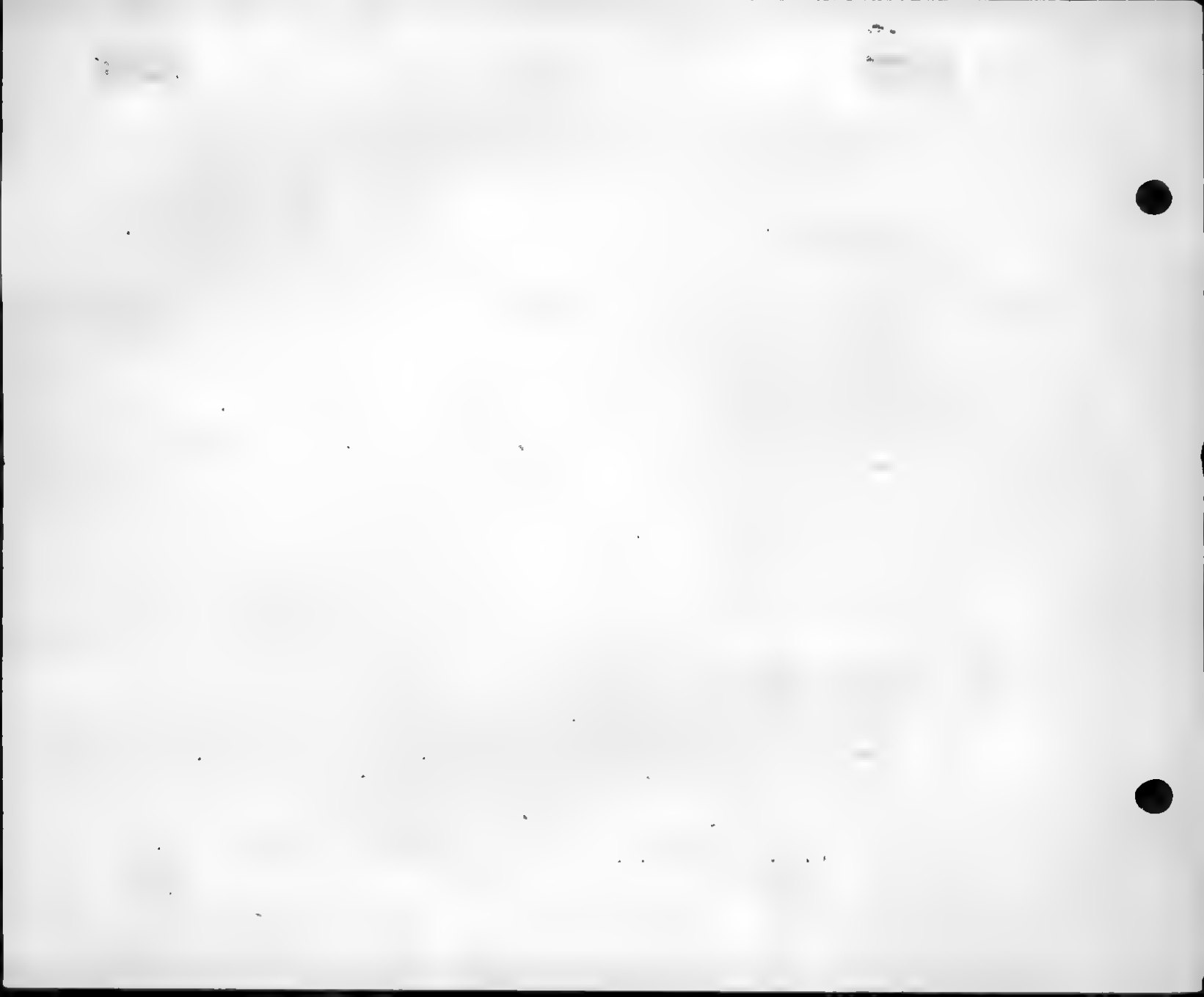
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G387 4/15/67 pc

CERTIFICATE OF DEATH

04020

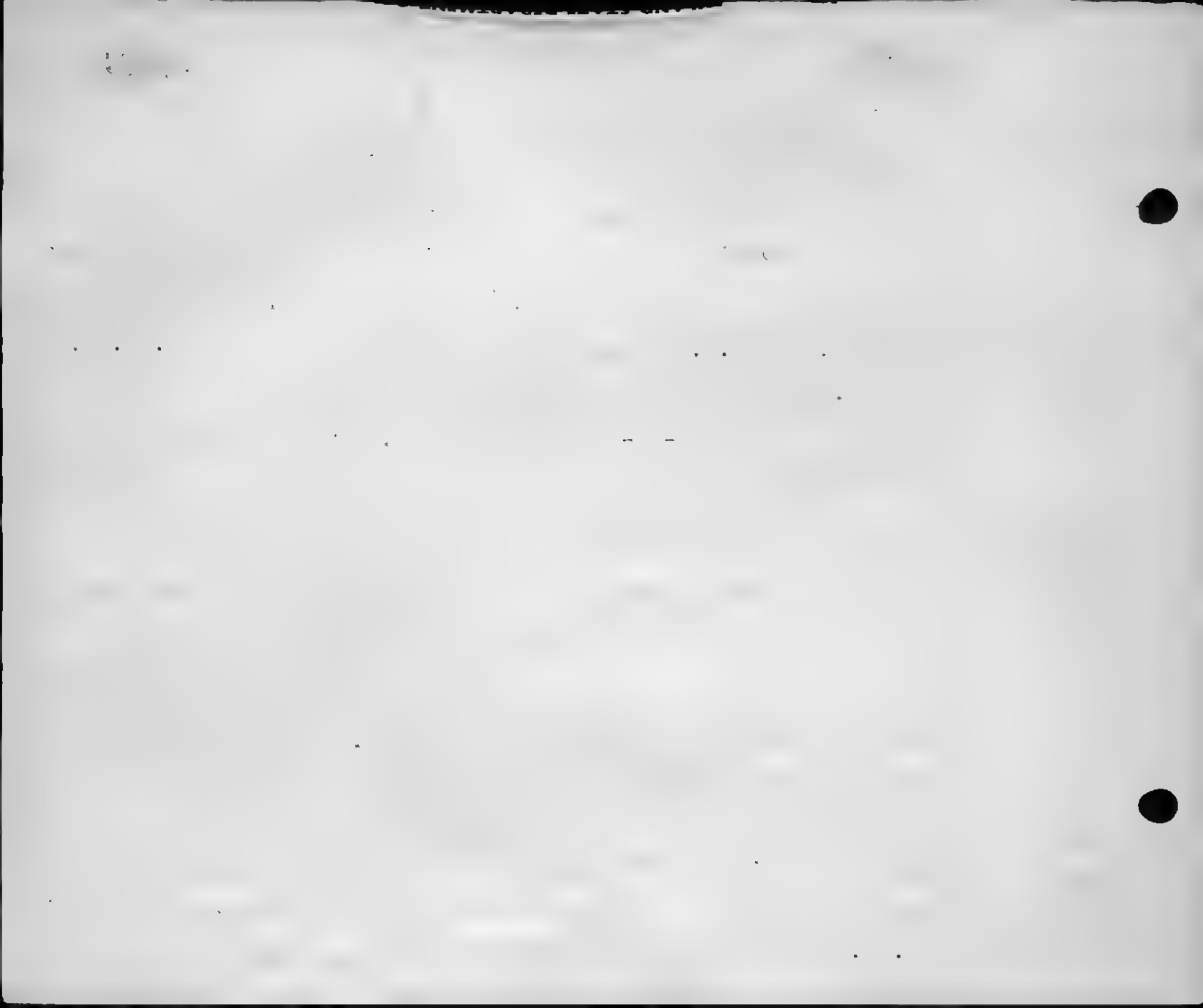
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Box 4102 Frank Tipper Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary E Butler		4. DATE OF DEATH Month Day Year March 28 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1892
9. AGE (In years last birthday) 44/75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 16 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Prince Georges Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rhyanelder Butler		14. MOTHER'S MAIDEN NAME Emily Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Clarence Butler P.O. Box 25		Address Cheltenham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Adenocarcinoma of Rectum (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from March 27, 1967 , to March 28, 1967 , that the (we) last saw the deceased alive on March 28, 1967 , and that death occurred at 5:00 PM , from causes and on the date stated above.			
22a. SIGNATURE J. A. Garcia, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) J. A. Garcia, M.D.		22b. DATE SIGNED 3/27/67	
22d. ADDRESS Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 1-1967	
23c. NAME OF CEMETERY OR CREMATORY Brooks Church Cem.		23d. LOCATION (City or Town) (County) (State) Nottingham Pr. Geo. Md.	
24. FUNERAL DIRECTOR Martell Adams Aguas, Md.		25a. REC'D BY REGISTRAR APR 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04022						04021					
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5711 Jamestown Road						d. STREET ADDRESS 5711 Jamestown Road					
3. NAME OF DECEASED (Type or print) David Mannie Callis						4. DATE OF DEATH March 5 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/25/1876		9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor G.M.O. R.R. (Retired)						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harrison R. Callis						14. MOTHER'S MAIDEN NAME Elizabeth Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no						16. SOCIAL SECURITY NO. 718-07-6493		17. INFORMANT Kathleen C. McManus (same as above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO (b) General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 2 wks 4 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1962 to 3/5/67, that (I) (we) last saw the deceased alive on 2/28/1967, and that death occurred at 4:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE David S. Clayman M.D.						22b. ADDRESS 6311 Balto. Ave Riverdale, Md		22c. DATE 3/5/67			
22c. PHYSICIAN'S NAME (Type) David S. Clayman											
23a. BURIAL, CREMATION, REMOVAL (Specify) removal			23b. DATE THEREOF 3/7/67		23c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery			23d. LOCATION (City, town or county) Meridian, Mississippi (State)			
24 FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company						ADDRESS Washington, DC		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						DATE MAR 8 1967		f. Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1-67

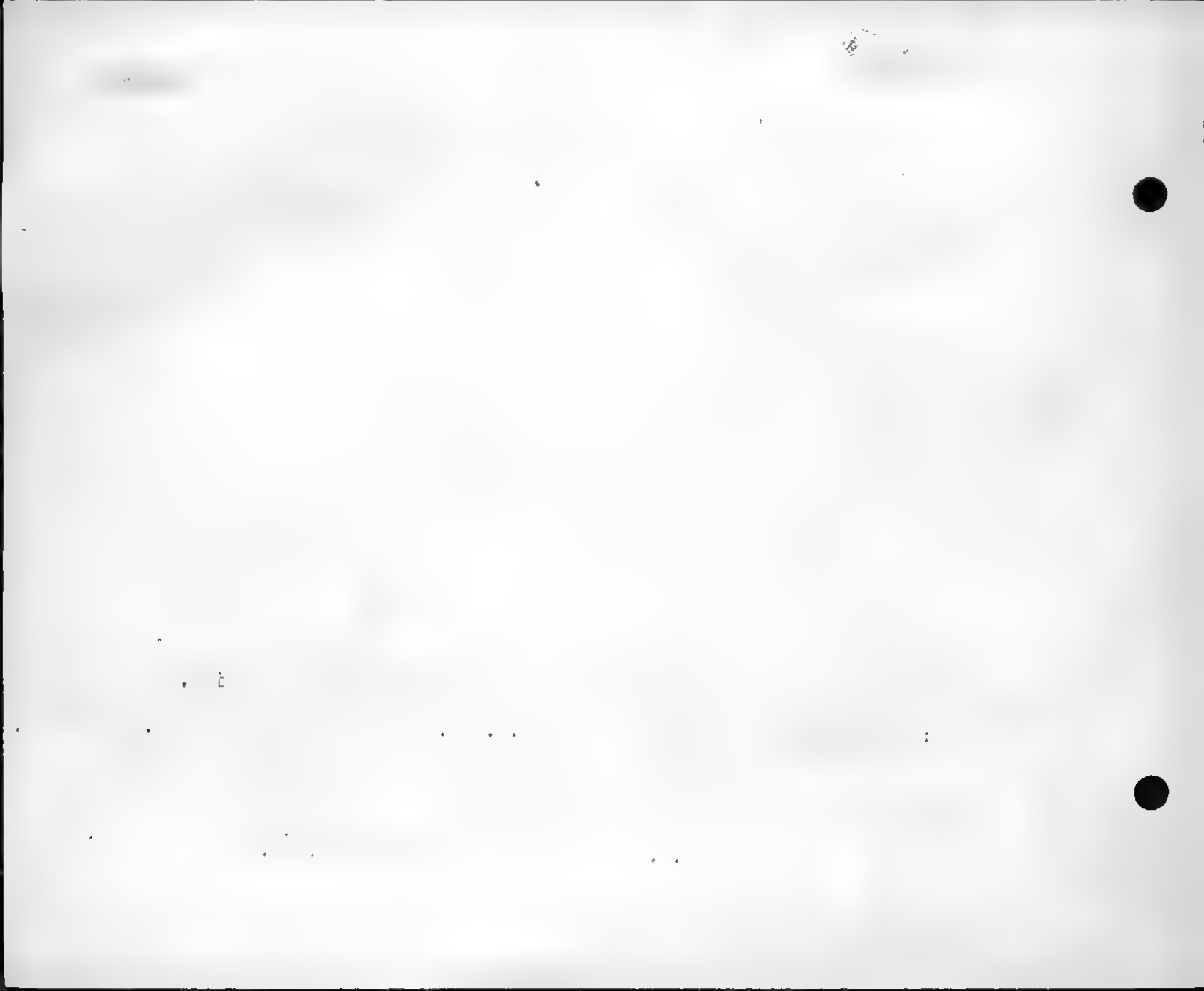
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04023

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04022

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Pennsylvania b COUNTY <input checked="" type="checkbox"/>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN b 45 min.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e STREET ADDRESS Howellville Road 460 Howellville Road	
3 NAME OF DECEASED (Type or print) First James Middle Fleming Last Carter		4 DATE OF DEATH Month March Day 10 Year 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-14-45
9 AGE (In years lost birthday) 21 yrs		10 IF UNDER 1 YEAR Months 10 Days 10	11 IF UNDER 24 HRS Hours 10 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Baltimore, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilmer G. Carter		14 MOTHER'S MAIDEN NAME Margaret E. Gibson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 216-44-0203	
17 INFORMANT Wilmer G. Carter (Father)		Address Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intra-abdominal hemorrhage 9164 DUE TO (b) Trauma DUE TO (c) Auto accident		INTERVAL BETWEEN DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car involved in head-on collision.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:50PM m 3-10-67 19		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) U.S. Rt. 1 at intersection of Rt. 193		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-11-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 13/1967	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial Gardens		23d. LOCATION (City or town) (County) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR Eugenia K. Seitz		25. BY REG. CLERK MAR 13 1967	
5209 York Road Seitz Funeral Home		Balto. Md. 21212	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

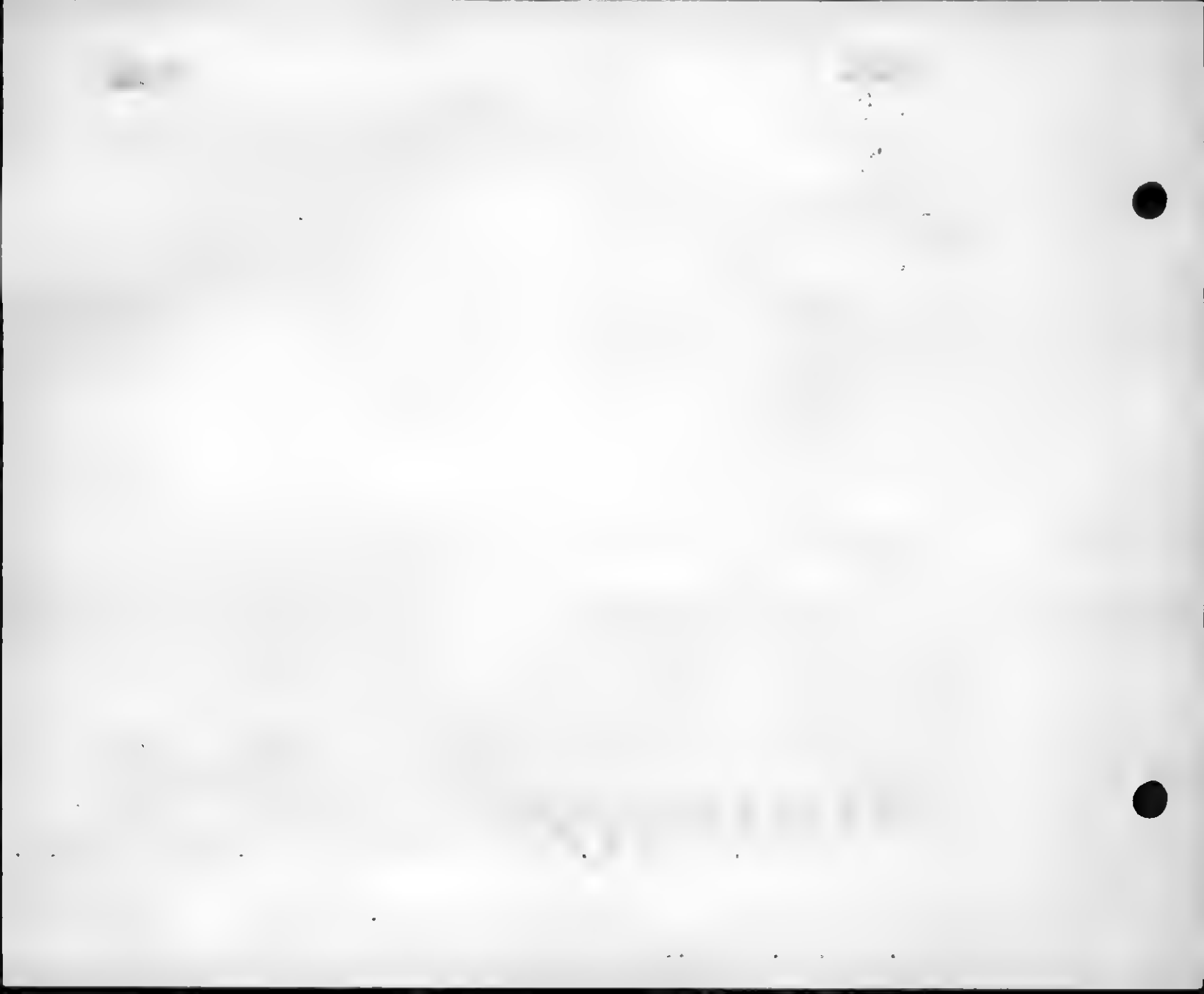
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #11 info. taken from birth cert.

04024

CERTIFICATE OF DEATH

04023

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB 10 hrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks				16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1303 - 58th Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Chinn				4. DATE OF DEATH Month March Day 3 Year 19 67			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1967	
9. AGE (In years last birthday) yrs		10. MONTHS		11. DAYS		12. HOURS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pr. Geo. Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jack Isaac Chinn				14. MOTHER'S MAIDEN NAME Roseal Marie Merritt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7625 Electroclasis neonatorum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from March 3, 1967 , to March 3, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 3:00 M from causes and on the date stated above.							
22a. SIGNATURE Andrew G. Aronfy				ATTENDING PHYS. <input type="checkbox"/> MED. DIR. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) Andrew G. Aronfy, M.D.				22d. ADDRESS 6803 Good Luck Road, New Carrollton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/11/67		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen Hosp		23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



04025

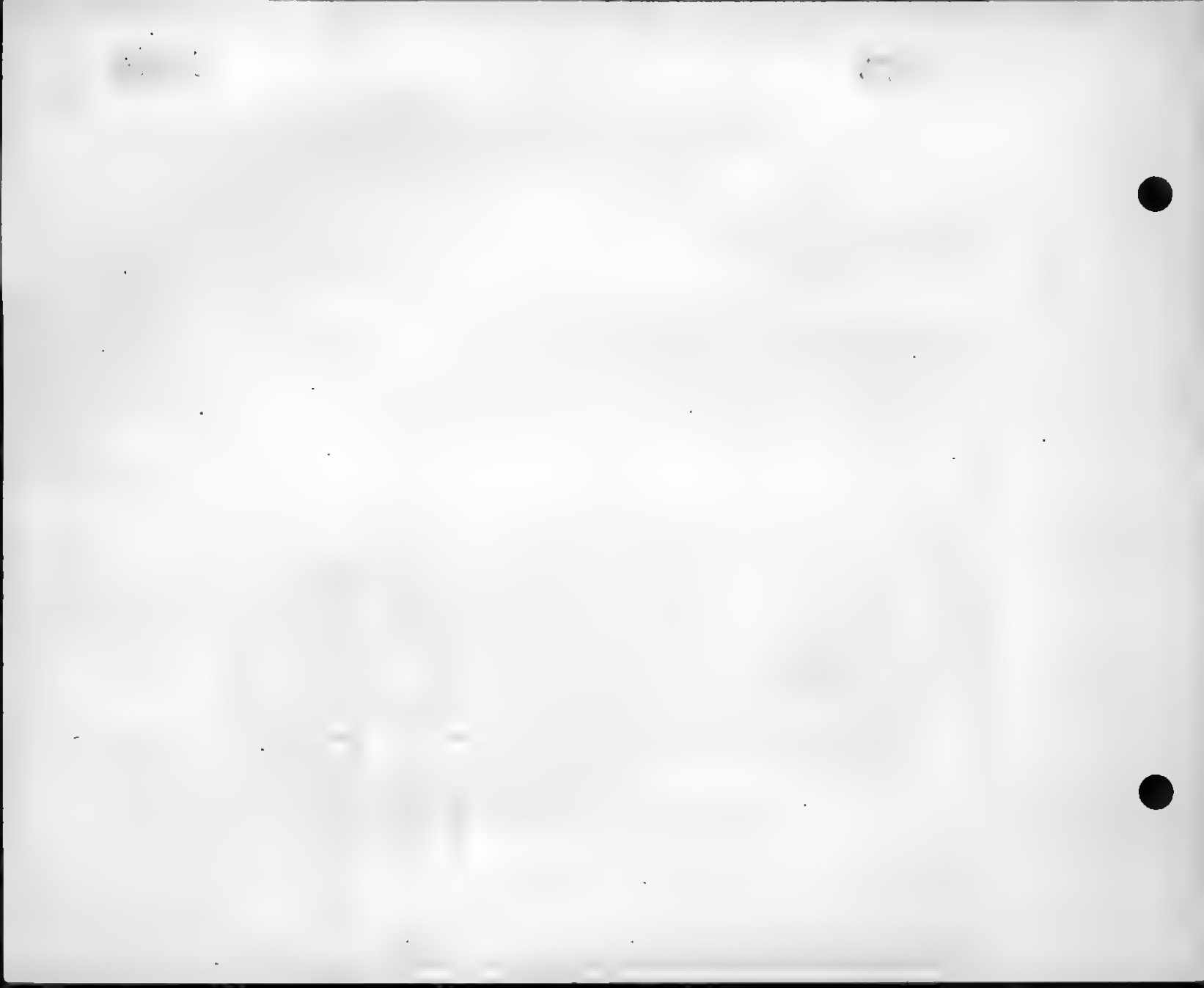
CERTIFICATE OF DEATH

04024

1 PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>1</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>		d. STREET ADDRESS <i>2221 30th St. S.E.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Southern Md Hosp Center</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John L. CLARK</i>		4. DATE OF DEATH Month <i>MARCH</i> Day <i>27</i> Year <i>1967</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-15-1884</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>State Dept</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Frank Clark</i>		14. MOTHER'S MAIDEN NAME <i>Lda Virginia Sheets</i>	
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>579-44-6093</i>	
17. INFORMANT <i>Mrs. Rozetta B. Larrison</i>		Address <i>AS. D.</i>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4. X Uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Renal Failure</i> DUE TO (c) <i>Cardiorenal vascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3-5 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A JPTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3/24</i> , 19 <i>67</i> , to <i>3/27</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/27</i> , 19 <i>67</i> , and that death occurred at <i>7:50</i> P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Alfred Lajon</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Alfred Lajon</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>3-30-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	23d. LOCATION (City or Town) (County) (State) <i>Switzland Md</i>
24. FUNERAL DIRECTOR <i>Lee FUNERAL HOME</i>		25. REC'D BY REGISTRAR <i>APR 3 1967</i>	
25a. ADDRESS <i>300-4 ST NE</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death Certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

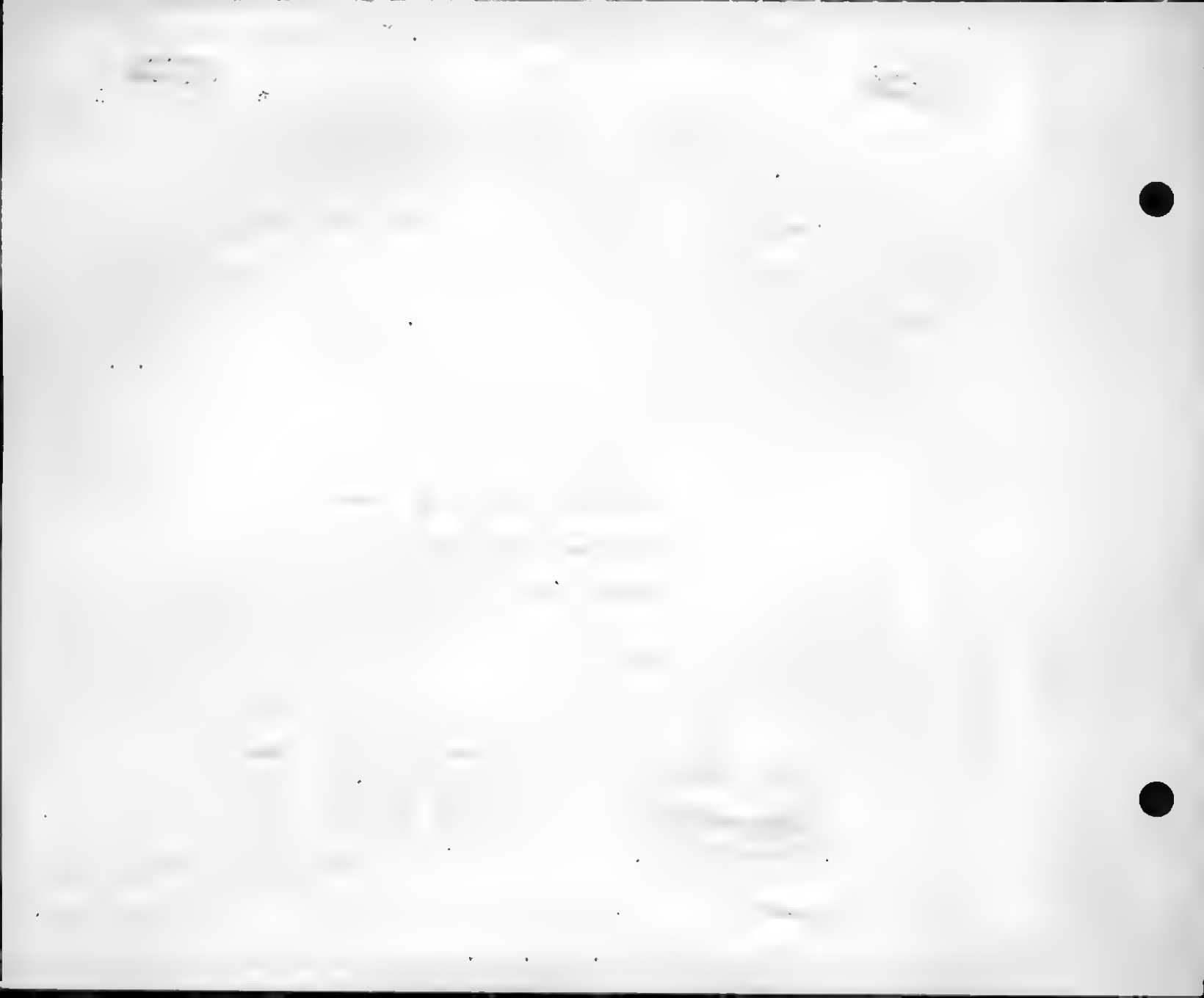
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04026

04025

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 6800 96th Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Jean (Jeanette) Cohen		4. DATE OF DEATH Month Day Year March 27 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Aug., 1905
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Scranton Pa	
11. BIRTHPLACE (County & State, or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Katz		14. MOTHER'S MAIDEN NAME Anna ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple pulmonary Emboli.</u> DUE TO (b) <u>Rheumatic Heart Disease:</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Congestive Heart failure.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 23</u> , 19 <u>67</u> , to <u>March 28</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/28/67</u> 19 <u>67</u> , and that death occurred at <u>6:50AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>V. Hernandez, M.D.</u>		22b. DATE SIGNED March 28, 1967	
22c. PHYSICIAN'S NAME (Type) V. HERNANDEZ, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3-30-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Sharon Cemetery	23d. LOCATION (City or Town) (County) (State) Delaware County, Penna.
24. FUNERAL DIRECTOR Bernard Danzansky & Sons St. Wash. D.C.		25a. REC'D BY REGISTRAR MAR 30 1967	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

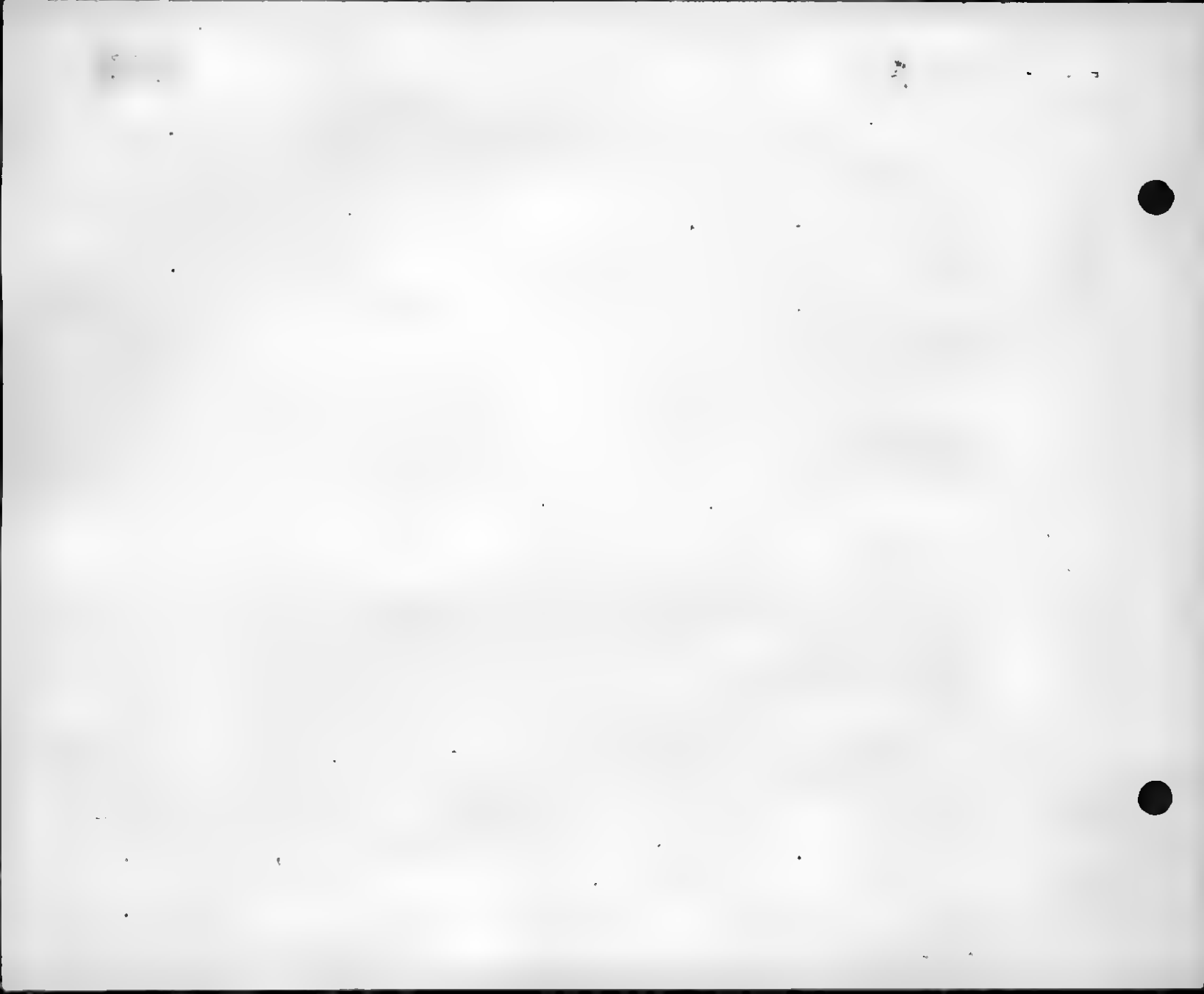
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04027

CERTIFICATE OF DEATH

04026

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 12 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3018- Curtis Drive SE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Nicolo Cono		4 DATE OF DEATH Month Day Year March 2nd. 19 67	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11-1890
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Sealtest Dairy		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife Angelina Cono		Address Same as Item #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular accident. 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular disease. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 1966, to 3-2, 1967, that (I) (we) last saw the deceased alive on 3-2 1967, and that death occurred at 11:40 M, from causes and on the date stated above.			
22a. SIGNATURE F. Taleghani		22b. DATE SIGNED March 3-67	
22c. PHYSICIAN'S NAME (Type) M. Far Taleghani		22d. ADDRESS 3611 -Branch Ave., SE Hillcrest Hghts Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-6-1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Bladensburg, Md.
24. FUNERAL DIRECTOR Simmons Bros. 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR DATE MAR 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

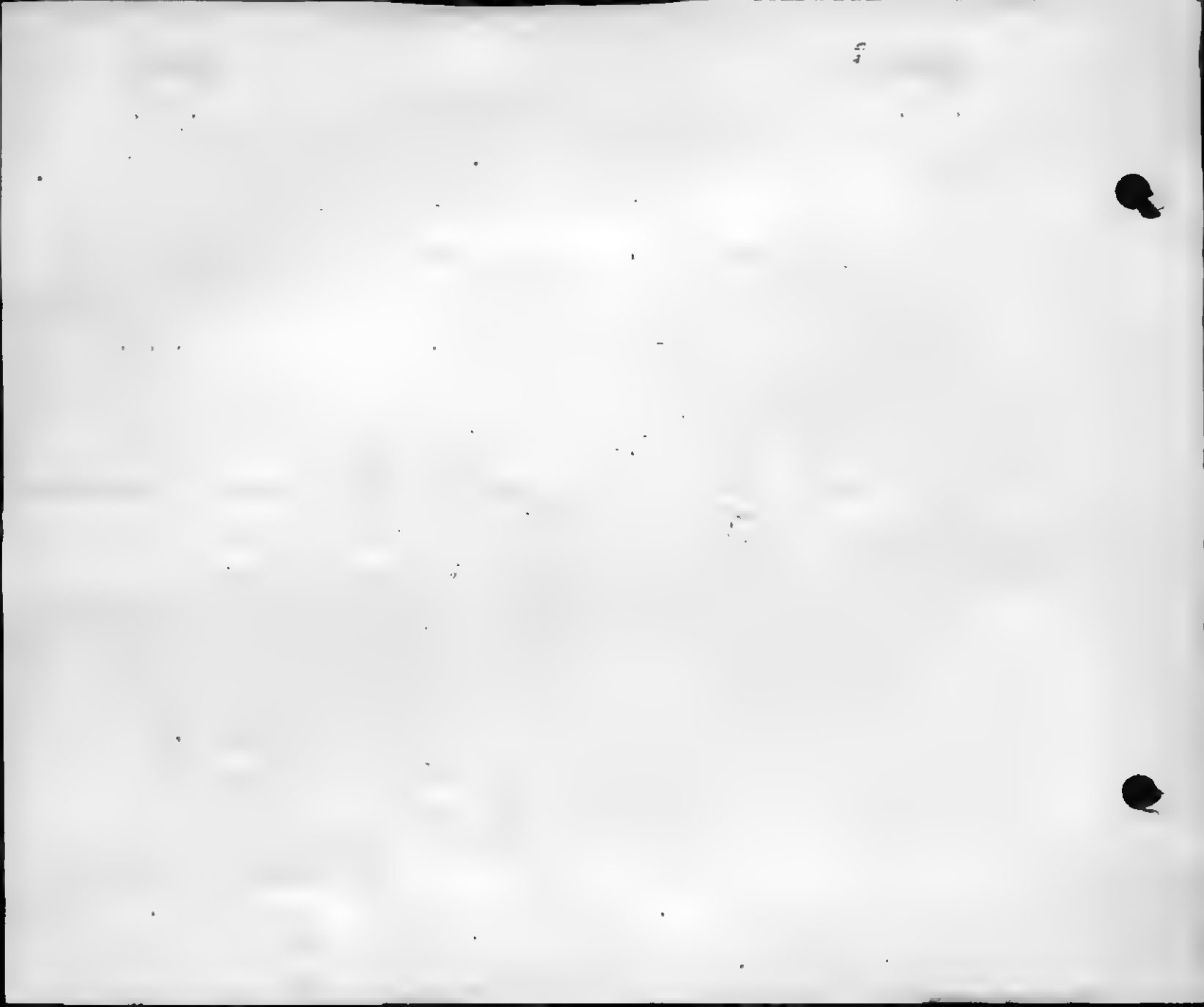


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be turned over to the funeral director. After this certificate has been signed by the attending physician and completely filled in, it should be turned over to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be turned over to the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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M

1. PLACE OF DEATH a. COUNTY Pr. Geo. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. LENGTH OF STAY IN 1b 10 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Magnolia Gardens Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle B. Last CONRAD		4. DATE OF DEATH Month MAR Day 20 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1882	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Karnes		14. MOTHER'S MAIDEN NAME Mary Ellen Mulloney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 494-52-3096		17. INFORMANT Miss Irene Conrad (above address)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Failure DUE TO Organic Brain Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis DUE TO Arteriosclerosis (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH minutes 4 weeks many years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Azotemia due to generalized arteriosclerosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB 6 1967 to MAR 20 1967 , that (I) (we) last saw the deceased alive on MAR 19 1967 , and that death occurred on MAR 20 1967 from the causes and on the date stated above.					
22a. SIGNATURE Paul A. DeWore		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/67		23c. NAME OF CEMETERY OR CREMATORY St. Francis Xavier Com. Cresson, Penna.	
23d. LOCATION (City, town, or county)		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.		ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR MAR 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

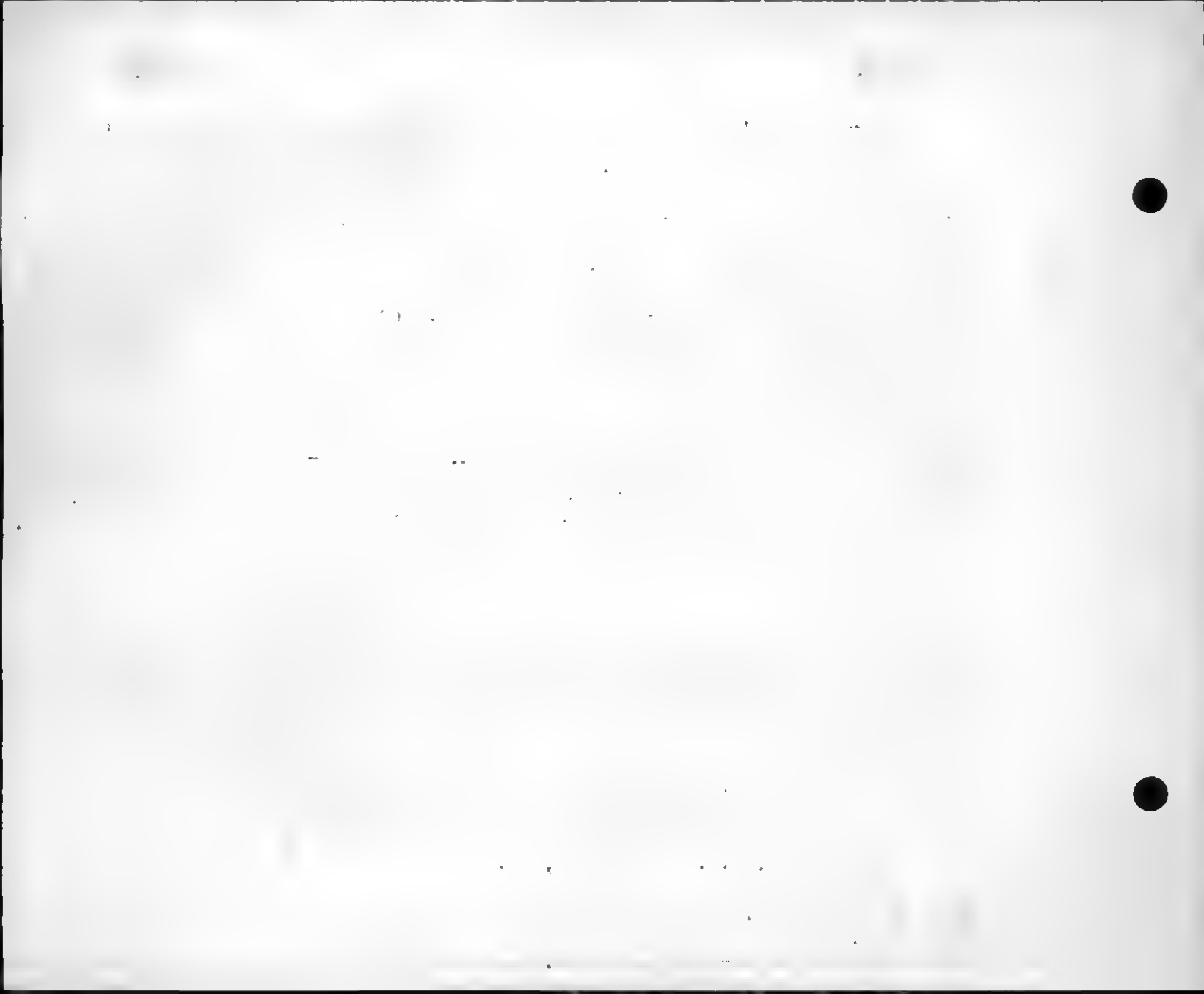
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04029

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04028

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a STATE Maryland b COUNTY Prince George's		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c LENGTH OF STAY IN b DOA		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d STREET ADDRESS 12325 Tilbury Lane		
3. NAME OF DECEASED (Type or print) First Middle Last Gertrude Minnie Cronin			4 DATE OF DEATH Month Day Year 3 15 19 67		
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-26-1903		9 AGE (In years, last birthday) 63 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) never worked		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Georgia	
13 FATHER'S NAME Isadore Koppel			14 MOTHER'S MAIDEN NAME Hannah Manne		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 067-38-8346		17 INFORMANT Paul R. Morrissey - same as #2 above	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 447 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Hypertensive arteriosclerotic heart disease (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22 DATE SIGNED 3-15-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		23b DATE THEREOF Mar. 16, 1967		23c NAME OF CEMETERY OR CREMATORY Mount Hope	
23d FUNERAL DIRECTOR Beverley E. Hopping		23e ADDRESS Hopping Funeral Home - Annapolis, Md.		23f LOCATION (City or town) (County) (State) Brooklyn New York	
25a REC'D BY REGISTRAR MAR 17 1967		25b REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

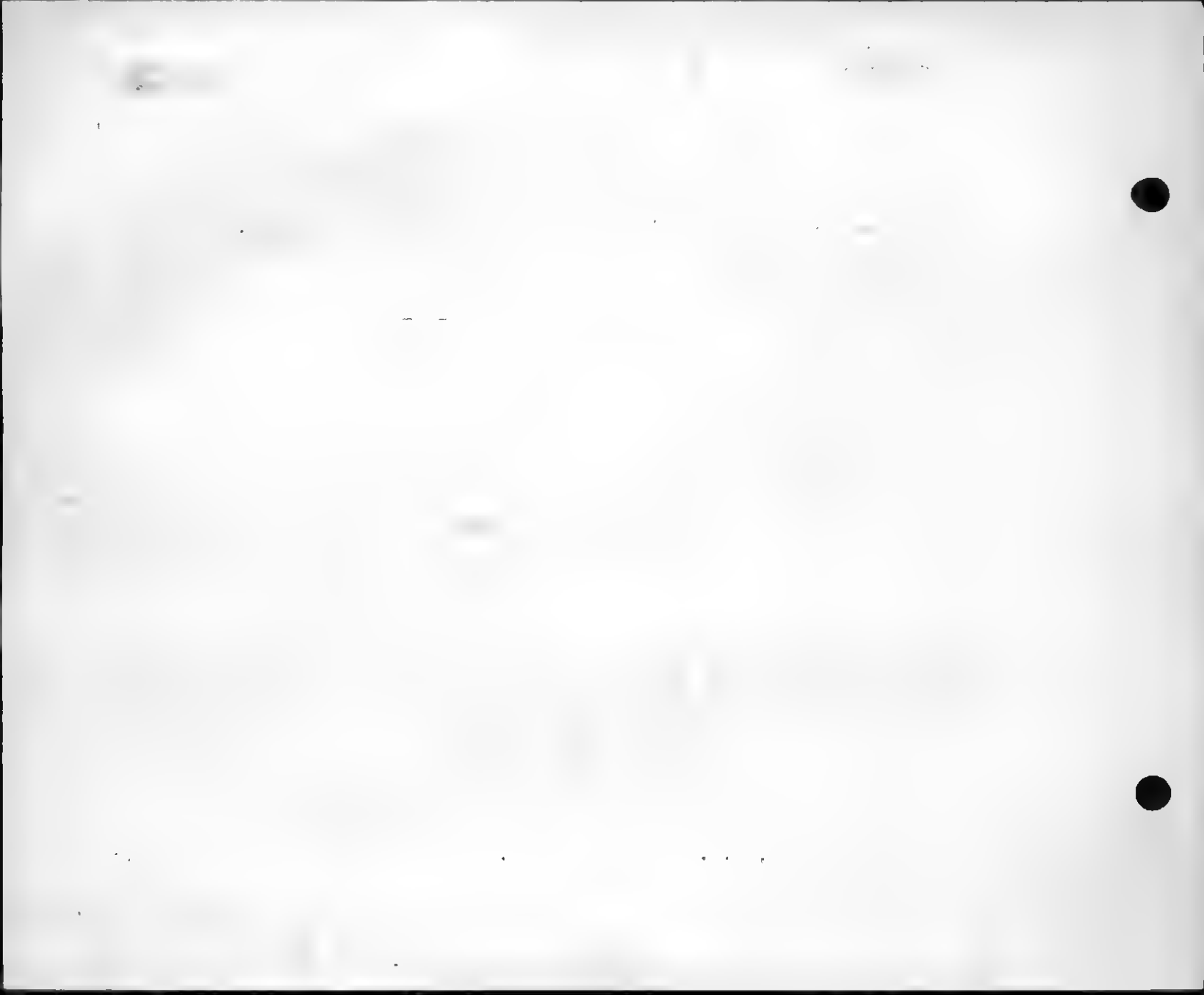
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G387 1/13/67 pc

04030

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04029

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY In To DOA			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d STREET ADDRESS 8401 Allendale Drive.			
3. NAME OF DECEASED (Type or print) First George Middle Henry Last Cummings				4. DATE OF DEATH Month 3 Day 19 Year 1967			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1911	9. AGE (In years last birthday) 55 yrs	10. UNDER 1 YEAR Months 19 Days 67	11. UNDER 24 HRS Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Cummings				14. MOTHER'S MAIDEN NAME Minnie Highsmith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				22. DATE SIGNED 3-20-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3/23/67		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State) Wilmington N. C.	
24. FUNERAL DIRECTOR Lee Funeral Home				ADDRESS Washington, D.C.		25a. REC'D BY REGISTRAR MAR 22 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

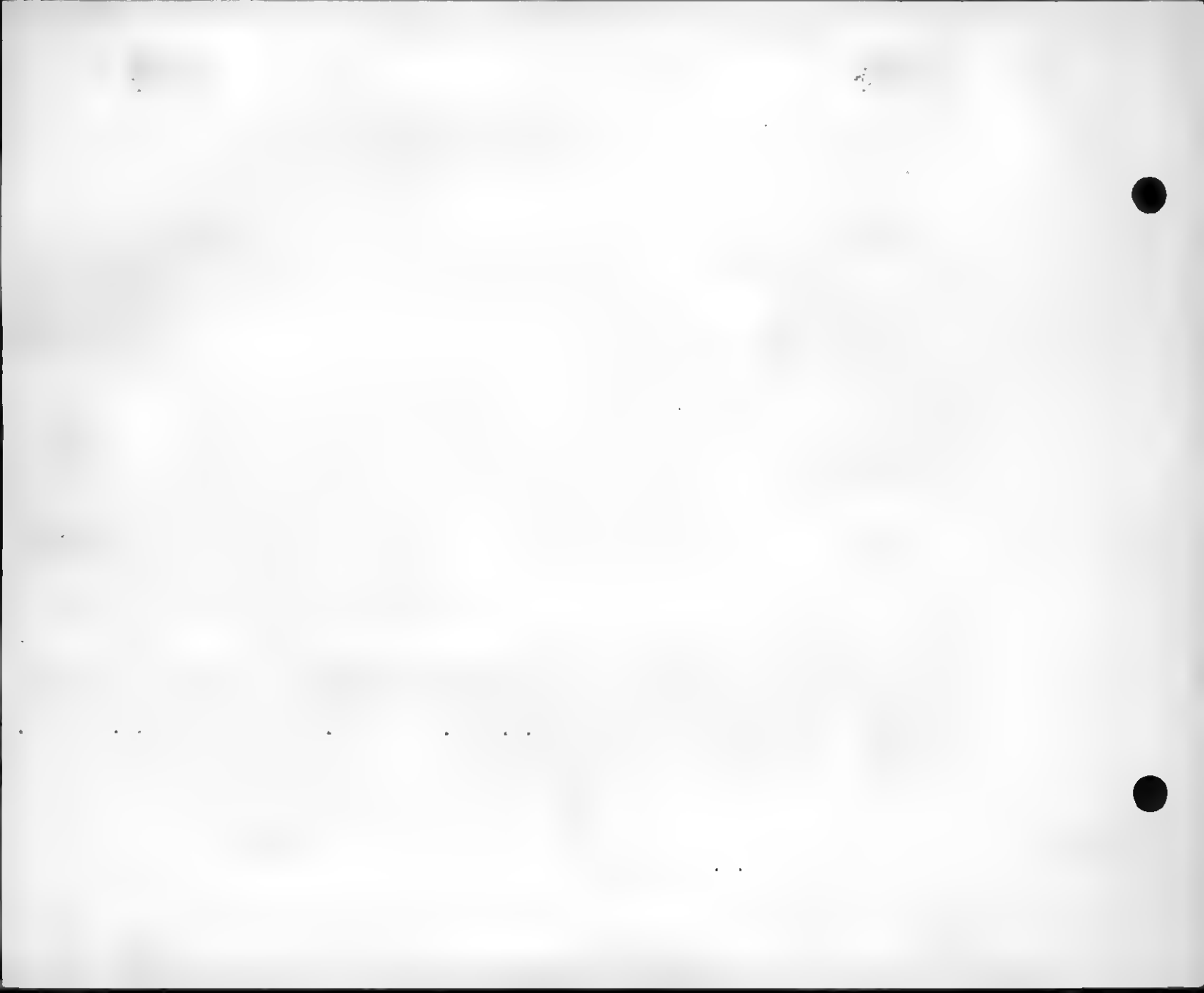
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04031

04030

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY In lb DOA			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown d. STREET ADDRESS Route 5, Old Court Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Robert Earl Cunningham First Middle Last			4 DATE OF DEATH 3 11 1967 Month Day Year		
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 18, 1945 lost birthday yrs		9 AGE (In years) 21 Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY School		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.			13 FATHER'S NAME Howard Cunningham		
14 MOTHER'S MAIDEN NAME Madeline Ridgely			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 216-44-2440		
16 SOCIAL SECURITY NO 216-44-2440			17 INFORMANT Mr. Howard Cunningham - Balto. 7, Md. Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Skull fracture DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) passenger in right front seat of car involved in collision			
20c TIME OF INJURY Month, Day, Year Hour o'm 11:50pm 3-10 1967		20d INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) U.S. Rte. 1 at Rte. 193	
		20f (City or town) P.G.		(County) (State) Md.	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-11-67	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 3-14-67		23c NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
23d LOCATION (City or town) Elkridge		(County) Md.		(State)	
24 FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sylkesville, Md.		25a REC'D BY REGISTRAR MAR 16 1967	
				25b REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

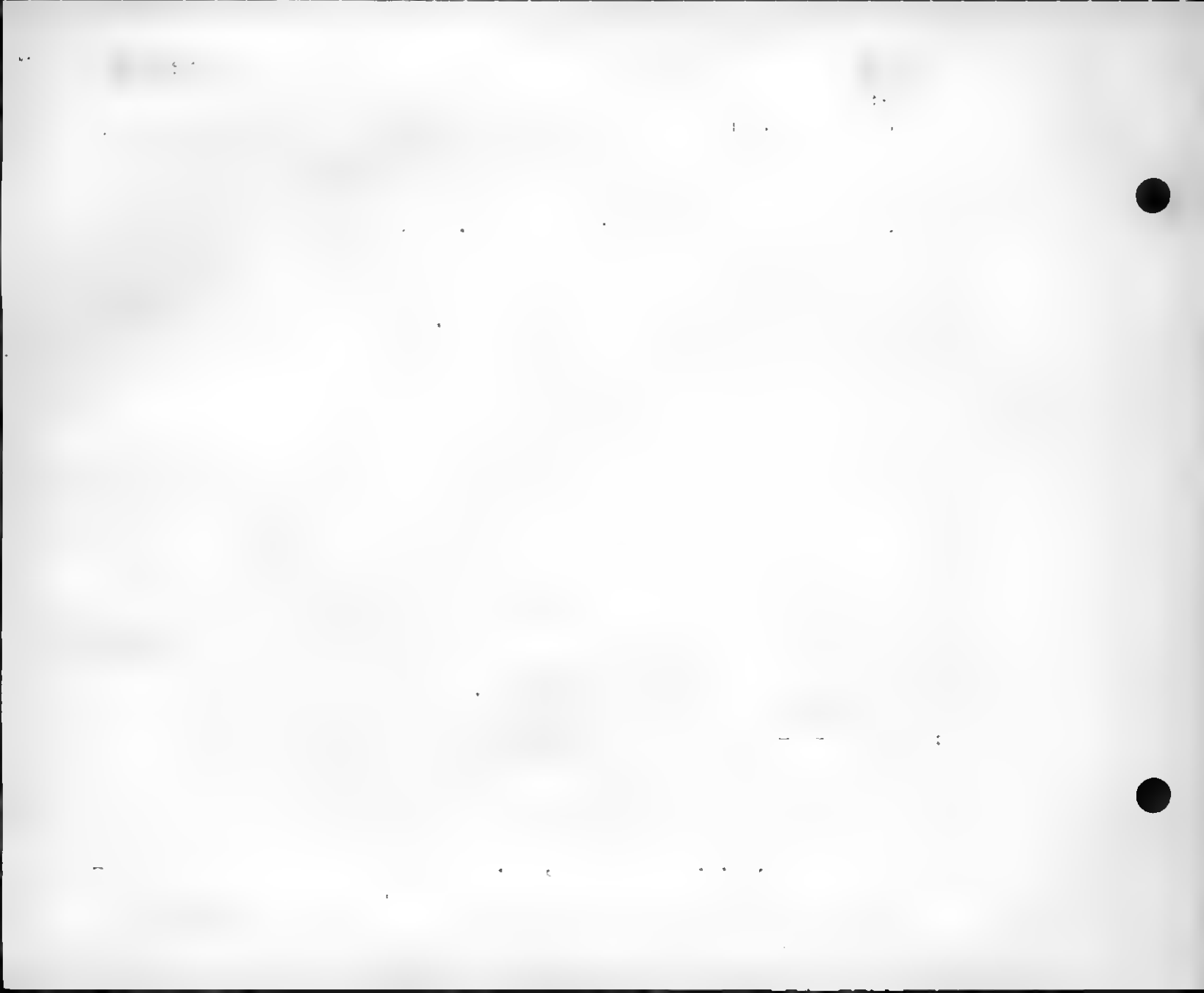
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #11, 12, 13 & 14 Film #G387 1/3/67 DC

04032

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04031

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 'b' DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e STREET ADDRESS Rt. 301, Box 4981	
3 NAME OF DECEASED (Type or print) First Brenda Middle Lois Last Curtis		4. DATE OF DEATH Month 3 Day 25 Year 19 67	
5. SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 26 Jan. 1950
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9 AGE (In years lost birthday) 17 yrs	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Annapolis, Md.	
13 FATHER'S NAME Ottway Curtis		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Mildred Brown		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 981X IMMEDIATE CAUSE (a) Gun shot wound of neck DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Shot by assailant.	
20c TIME OF INJURY Month, Day, Year Hour a.m. 5:45pm 3-25- 19 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> home	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) same as #2		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-27-67	
EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 4-1-67	23c NAME OF CEMETERY OR CREMATORY St. Carmel	23d LOCATION (City or town) (County) (State) Upper Marlboro Md
24 FUNERAL HOME ADDRESS Rollins Funeral Home 4339-4th		25a REC'D BY REGISTRAR MAR 29 1967 25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

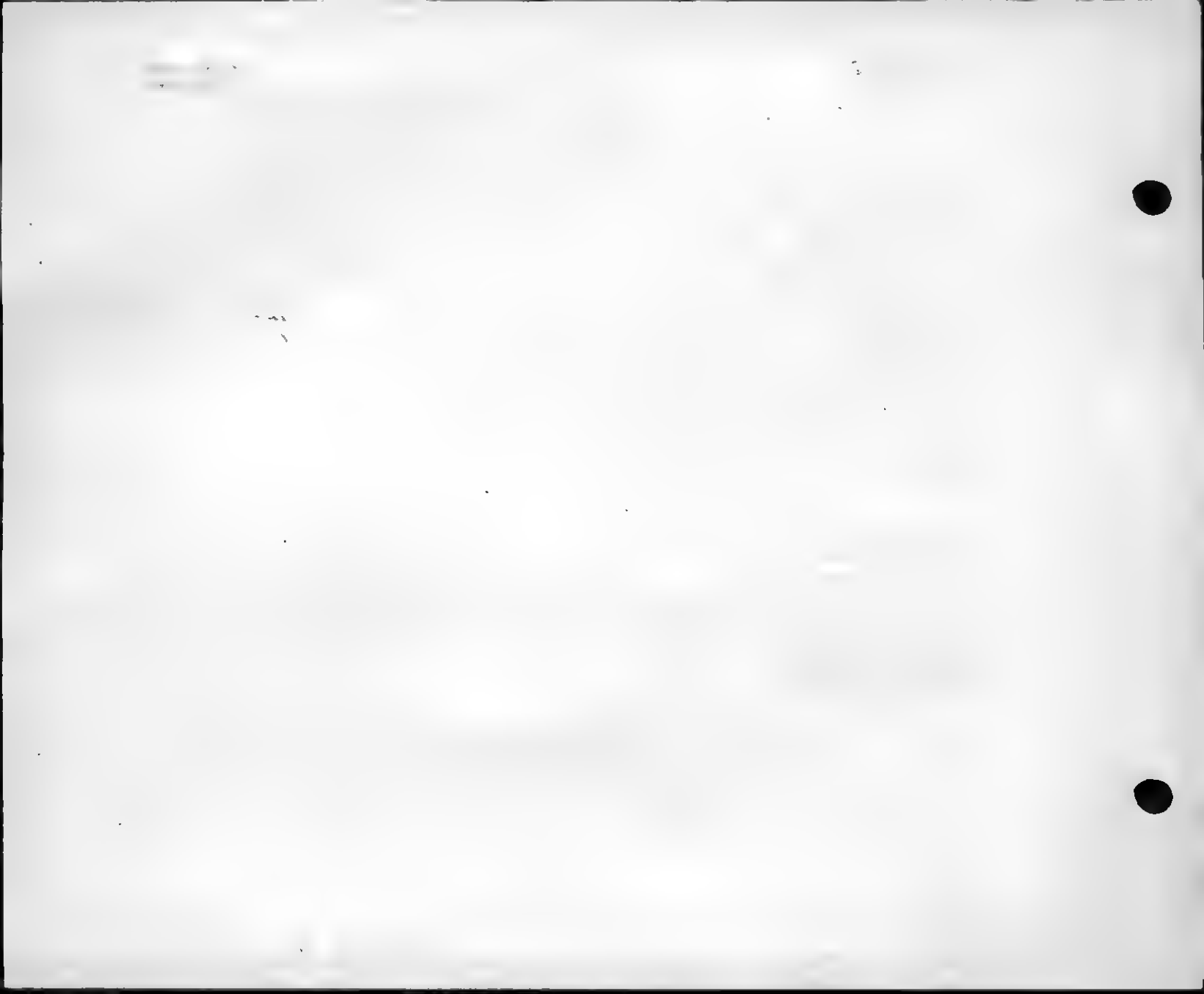
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04033

CERTIFICATE OF DEATH

04032

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE MD</u>		c. LENGTH OF STAY IN 1b <u>8 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR 4922 LA SALLE RD</u>		d. STREET ADDRESS <u>8411 GALVENTON RD</u>	
3. NAME OF DECEASED (Type or print) <u>TSABEL</u> <u>DARBY</u>		4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-30-82</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher, Bethesda</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES FITZPATRICK</u>		14. MOTHER'S MAIDEN NAME <u>EMILY DEMONET</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>577-01-6012</u>	
17. INFORMANT <u>Dr. Raymond</u>		Address <u>Cornell Manor</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>8 years</u> (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>8 years</u> (c) <u>8 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 30</u> , 19 <u>59</u> , to <u>Mar 29</u> , 19 <u>67</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>Mar 29</u> , 19 <u>67</u> , and that death occurred at <u>6:28 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Francis P. Pham</u> M.D.		22b. DATE SIGNED <u>Mar 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS P. PHAM M.D.</u>		22d. ADDRESS <u>1511-17 ST. N.W. WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>	23b. DATE THEREOF <u>Mar 31-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>Jakoma Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15ME (5)
6M 67

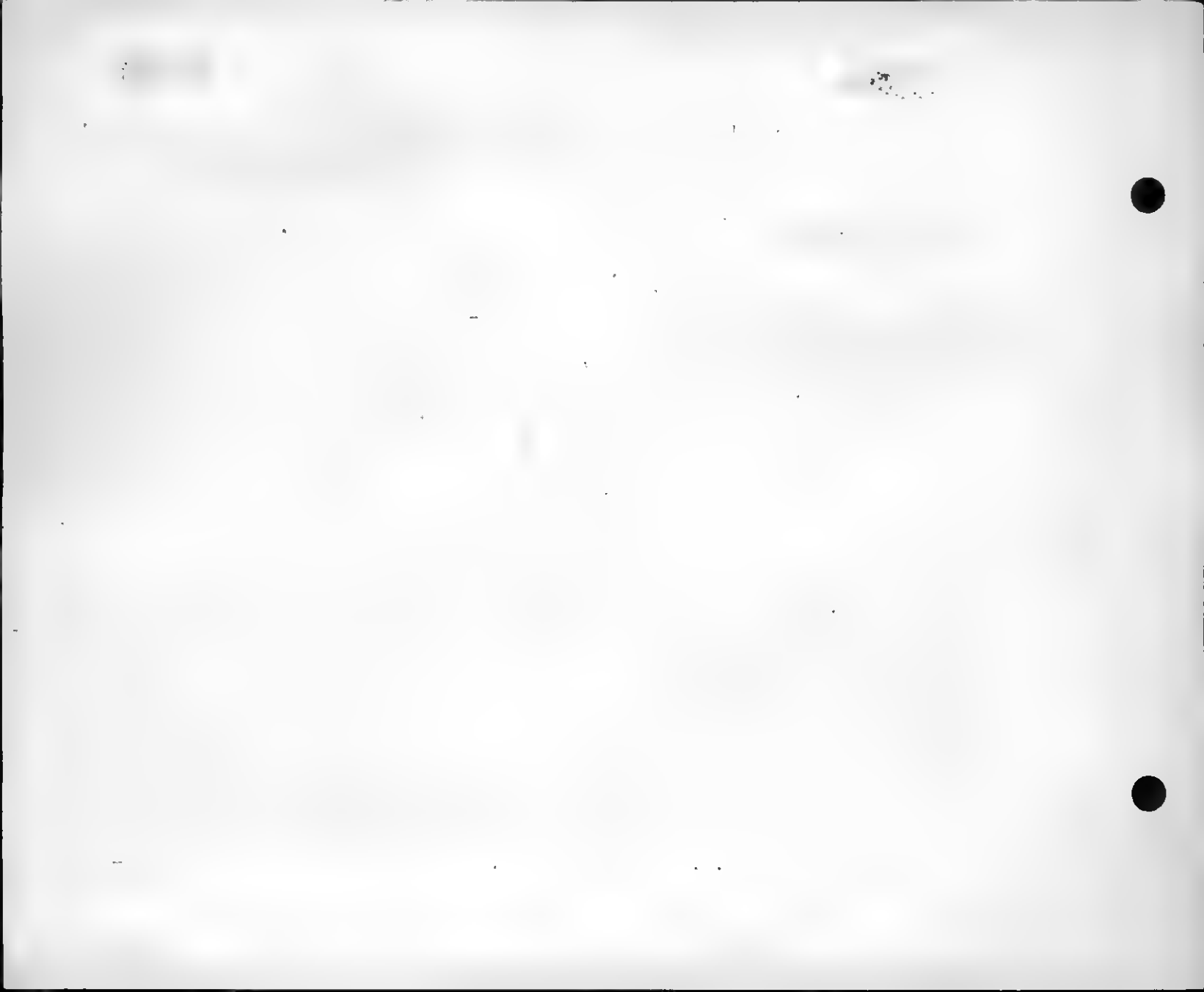
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04034

04033

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Glen Arden	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 8646 Johnson Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mary L. Deadwyler		4. DATE OF DEATH 3 2 19 67	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-18-1904
9 AGE (In years last birthday) 62 yrs		10 IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11 BIRTHPLACE (State or foreign country) GEORGIA	
12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME JIM FOOTE	
14 MOTHER'S MAIDEN NAME EMMA HITCHCOCK		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT BEROY DEADWYLER Address 8646 Johnson Ave Glen Arden	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION REMOVAL (Specify)	23b DATE THEREOF Mar. 6, 67	23c NAME OF CEMETERY OR CREMATORY Carver Cemetery	23d LOCATION (City or Town) (County) (State) Md.
24 FUNERAL DIRECTOR Charles E. Hunter 2212 Sherwood Rd		25a REC'D BY REGISTRAR March 6 1967	25b REGISTRAR'S SIGNATURE Charles Judge



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

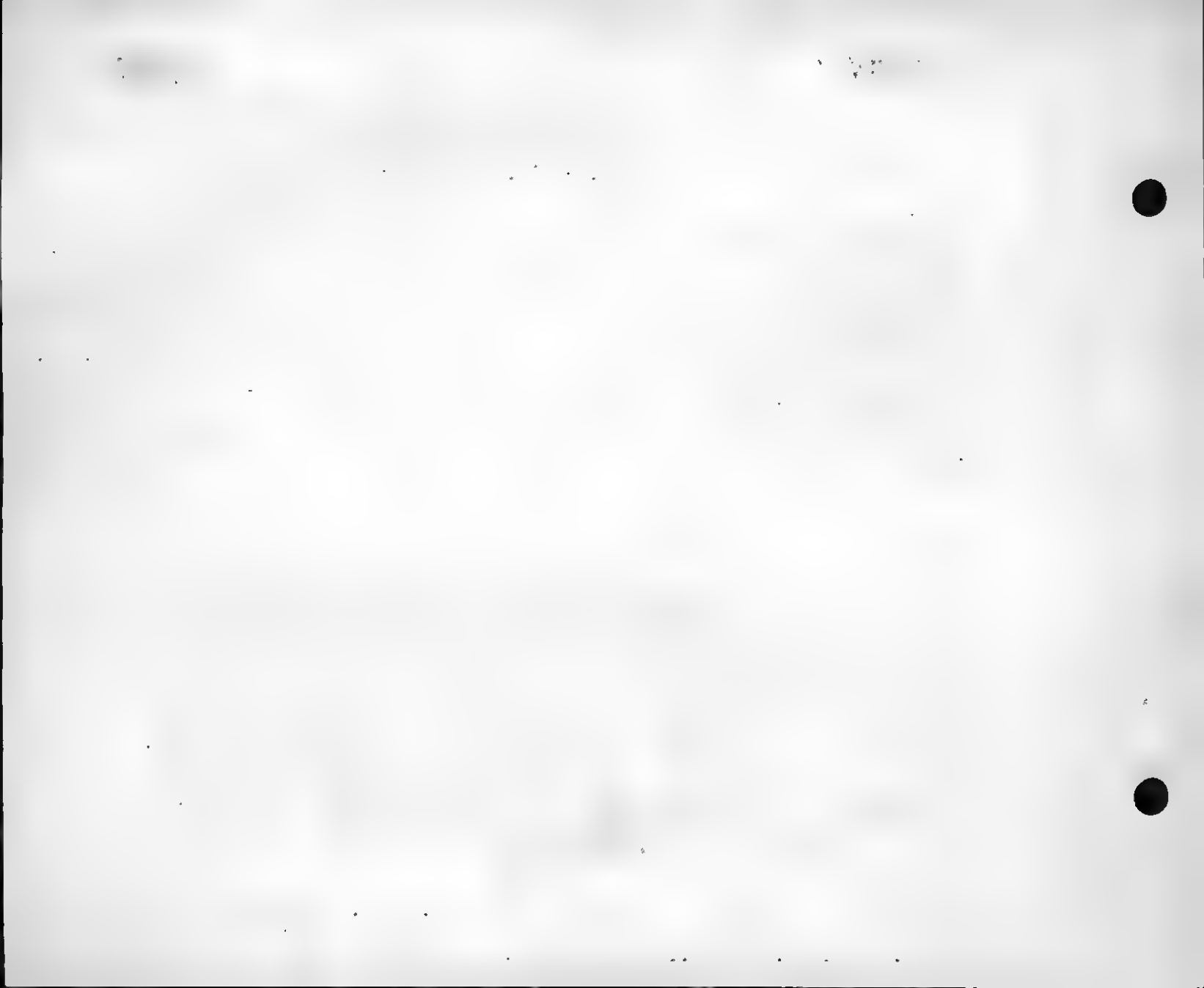
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04035

CERTIFICATE OF DEATH

04034

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 16 8 hrs. 45 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 6407 Jay Street	
3. NAME OF DECEASED (Type or print) Baby		First Boy		Last Deal	
4. DATE OF DEATH Month March		Day 4		Year 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 4, 1967		9. AGE (In years last birthday) yrs. 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland	
13. FATHER'S NAME Joseph Leo Queen		14. MOTHER'S MAIDEN NAME Janice Sheila Deal			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address As above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 1000 IMMEDIATE CAUSE (a) Pulmonary atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Prematurity DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 3/4/1967 , to 3/4/1967 , that (I) (we) last saw the deceased alive on March 4, 1967 , and that death occurred at 10:45 AM , from causes and on the date stated above.					
22a. SIGNATURE Andrew G. Aronfy		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) Andrew G. Aronfy		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/11/67		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly, PG, Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md.		25a. RECEIVED BY REGISTRAR MAR 15 1967		25b. SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04036

CERTIFICATE OF DEATH

04035

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN TB <u>2 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home - 6500 Rig</u>				d. STREET ADDRESS <u>14706 New Hampshire Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Blanche</u> <u>M</u> <u>Deane</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>15</u> <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/20/1884</u>	
9. AGE (In years last birthday) <u>83</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Nova Scotia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Murphy</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Mooney</u>				15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>			
16. SOCIAL SECURITY NO <u>022-40-0236</u>				17. INFORMANT <u>Daughter-in-law</u> Address <u>14706 New Hampshire Ave Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurring Cerebral Vase Accidents</u> DUE TO <u>weeks</u> (c) <u>Generalized Atherosclerosis</u> <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>1</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>1</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 17</u> , 19 <u>67</u> , to <u>March 15</u> , 19 <u>67</u> , that (we) lost the deceased on <u>March 15</u> , 19 <u>67</u> , and that death occurred at <u>10:00</u> A.M. from causes on and on the date stated above.							
22a. SIGNATURE <u>Harold W. Draper</u> M.D.				22b. DATE SIGNED <u>15 March 67</u>		22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER</u>	
22d. ADDRESS <u>911 SILVER SPRING AVE, SILVER SPRING, MARYLAND</u>				22e. REC'D BY REG STRAR <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>3/15/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LAWRENCE CEMETERY - COLMAR MANOR</u>		23d. LOCATION (City or Town) (County) (State) <u>SILVER SPRING, MD</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBER, INC. SILVER SPRING, MD</u>				25. REC'D BY REG STRAR <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

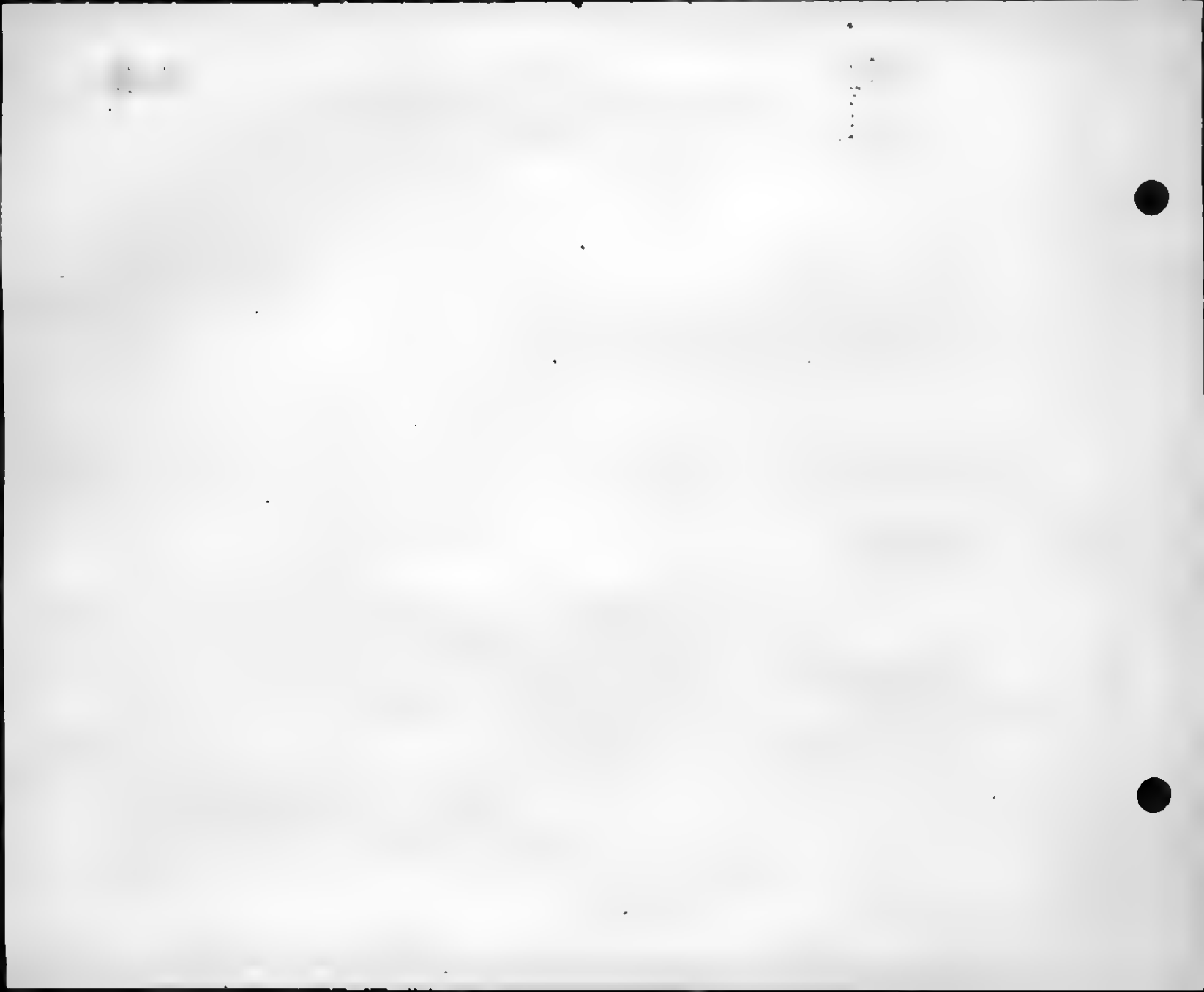
04037

CERTIFICATE OF DEATH

04036

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Res denote before admission) a. STATE <u>Md</u> b. COUNTY <u>B.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel General Hosp</u>		d. STREET ADDRESS <u>3358 Old Line Ave</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Gabriel F. DeAngelis</u>		4 DATE OF DEATH Month Day Year <u>March 16 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>superintendent maint newspaper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York City, N.Y.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francis DeAngelis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Klepach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>110-07-25904</u>	
17. INFORMANT <u>Marguerite Muller, Laurel Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesenteric artery thrombosis</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>Feb. 1965</u> to <u>3-17-</u> 1967 that (1) (we) last saw the deceased alive on <u>3/16 1967</u> , and that death occurred at <u>11:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Frank Weaver Jr.</u>		22b. DATE SIGNED <u>3/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK WEAVER JR.</u>		22d. ADDRESS <u>LAUREL, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem. Laurel Md.</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel Md.</u>
24. FUNERAL DIRECTOR <u>de Witt Canale dean Laurel Md</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

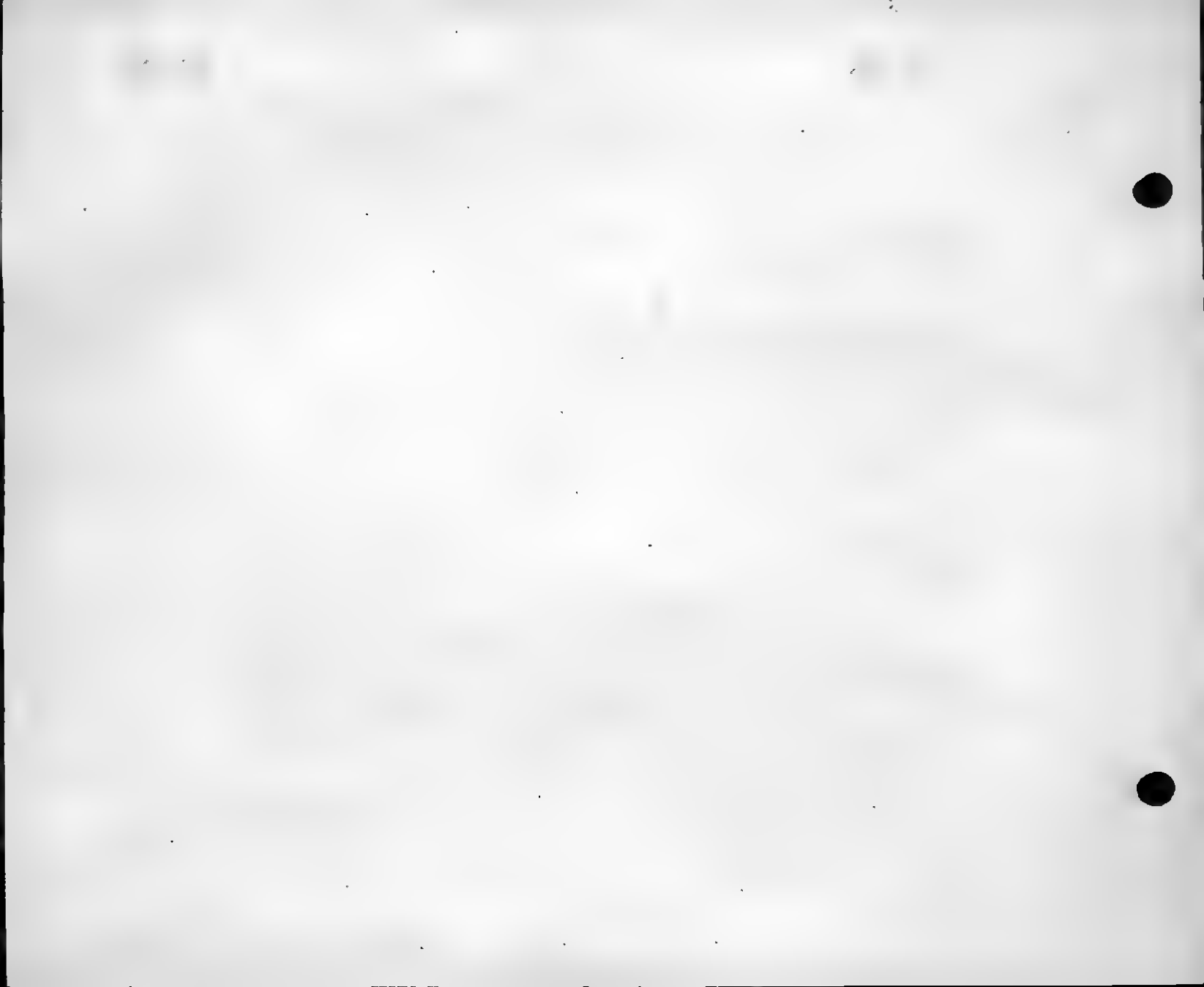
Item #9 Film #3387 3/28/67 pc

04038

CERTIFICATE OF DEATH

04037

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EAST RIVERDALE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDENS Nsg. HOME</u>		e. STREET ADDRESS <u>5607 - 62ND AVE</u>	
3 NAME OF DECEASED (Type or print) <u>DOROTHY DEGRAFFENRIED</u>		4 DATE OF DEATH <u>MARCH 17 1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>CAUC.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/25/1889</u>
9 AGE (In years last birthday) <u>77 7/8</u> yrs.		10 IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11 BIRTHPLACE (County & State or foreign country) <u>WASHINGTON, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>LAFAYETTE KNAPP</u>		14 MOTHER'S MAIDEN NAME <u>IDA ROME</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>577-07-9177-D</u>	
17. INFORMANT <u>GAYLE NASH, R.N.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <u>7824</u> IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/14</u> , 19 <u>67</u> , to <u>3/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/17</u> , 19 <u>67</u> , and that death occurred at <u>6:00</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Leon Levitsky</u>		22b. DATE SIGNED <u>3/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEON LEVITSKY, M.D.</u>		22d. ADDRESS <u>MT RAINIER, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>3/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LEE'S CREMATORY</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON D.C.</u>
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>MAR 22 1967</u>	
ADDRESS <u>3004 D.C. WASH, DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

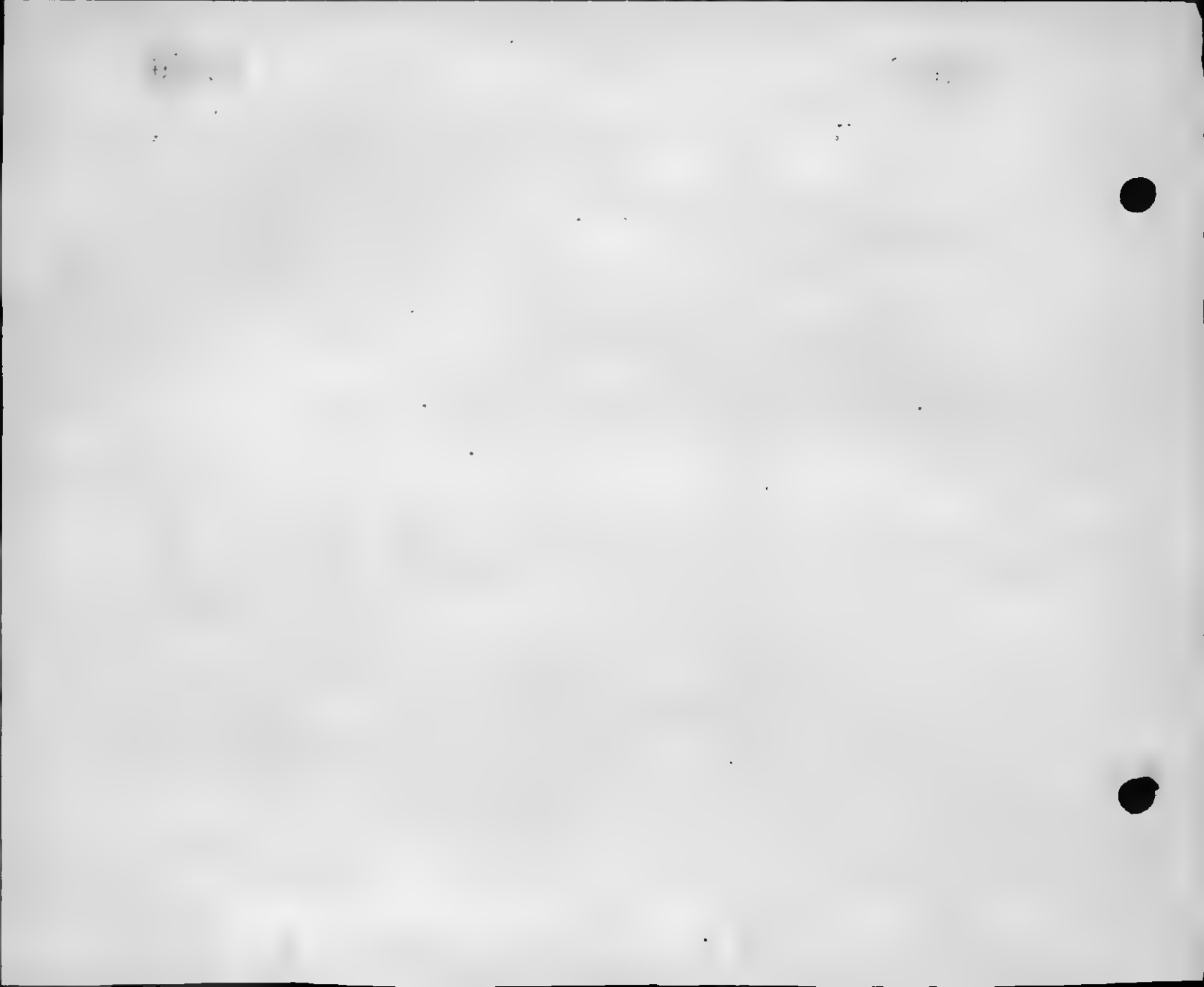
CERTIFICATE OF DEATH

04039

04038

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SOUTHERN MEDICAL CENTER, CLINTON, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON d. STREET ADDRESS 8728 SURRATTS ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JANET ELIZABETH DIXON		4. DATE OF DEATH Month MARCH Day 1 Year 19 67		5. SEX FEMALE			
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 14, 1914			
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA			
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME JOHN M. COY		14. MOTHER'S MAIDEN NAME CLARA M. DIEHL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT BERYL M. DIXON Address SAME AS # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Chronic Hypertension</i> DUE TO (b) <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 1963 to March 1, 1967 that (I) (we) last saw the deceased alive on February 1, 1967 and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert E. Wilhelm</i>				22b. DATE SIGNED MAR 6 1967			
22c. PHYSICIAN'S NAME (Type or print) DEWAMIN S PECOSON				22d. ADDRESS 6106 OLD SILVER HILL RD A D			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MARCH 4, 1967		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY			
23d. LOCATION (City, town or county) PRINCE GEORGES, MARYLAND		24 FUNERAL DIRECTOR'S SIGNATURE ROBERT E. WILHELM ADDRESS MARYLAND					
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 within the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

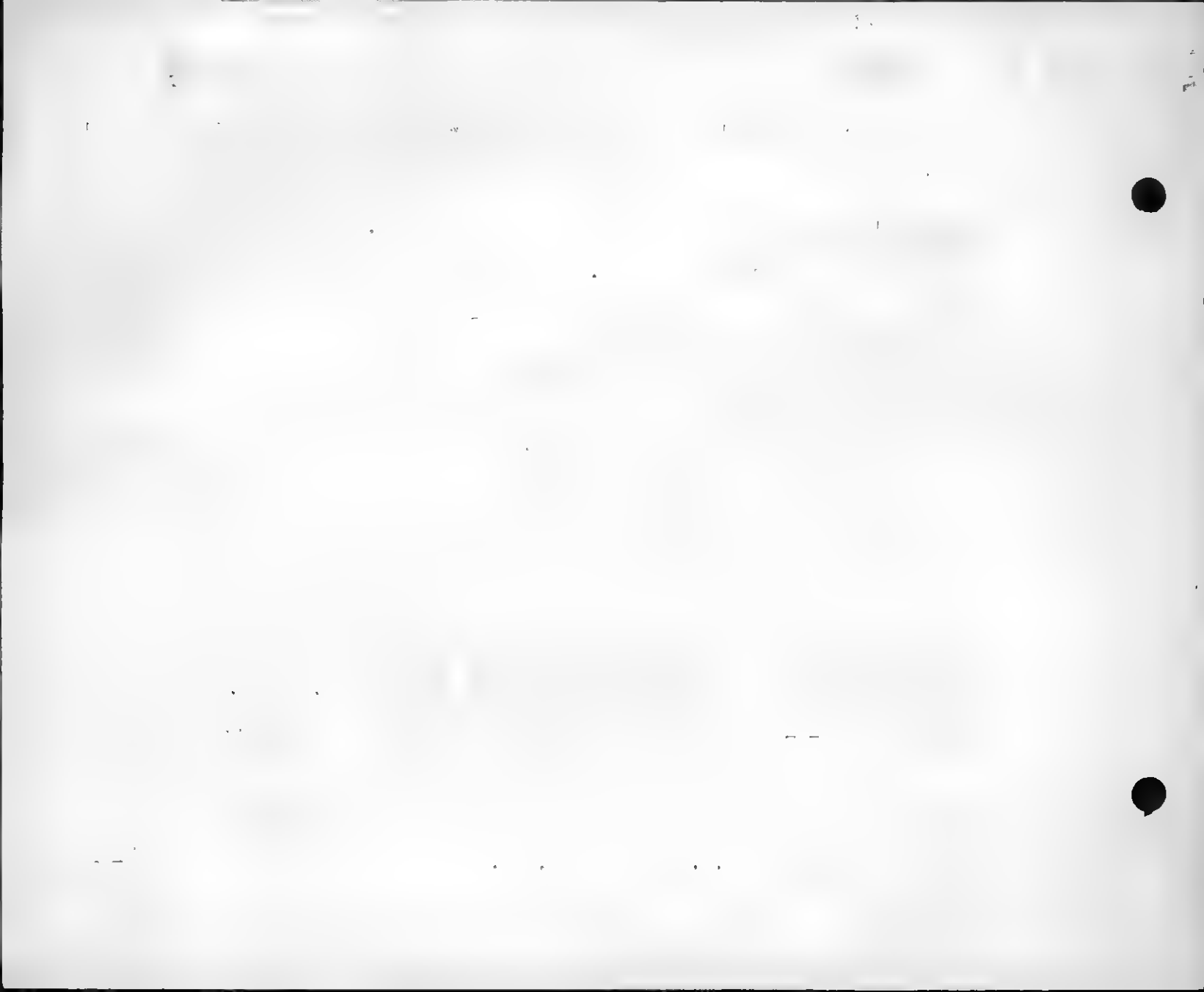
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04040

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04039

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN b. DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home		e. STREET ADDRESS Hyattsville	
3 NAME OF DECEASED (Type or print) Durdal F. Dodd		4 DATE OF DEATH 3 7 19 67	
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-11-1922
9 AGE (In years lost birthday) 45 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	
10b. KIND OF BUSINESS OR INDUSTRY GOETZ MEAT CO.		11. BIRTHPLACE (State or foreign country) ALABAMA	
12 CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME LEE F. DODD	
14. MOTHER'S MAIDEN NAME MARY TINGLE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. II	
16 SOCIAL SECURITY NO 418-18-5722		17. INFORMANT EDNA FULLER DODD Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO (b) 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Shot self thru mouth with 30 Cal. rifle.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Shot self thru mouth with 30 Cal. rifle.	
20c. TIME OF INJURY Month Day Year about 1:00pm 3-7-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> bedroom of home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) same as #2		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-8-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 11 MAR 1967	23c. NAME OF CEMETERY OR CREMATORY WINSTON MEM CEM.	23d. LOCATION (City or town) (County) (State) HALEYVILLE ALABAMA
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.		25. RECEIVED BY REGISTRAR 10 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AT5ME (5)
6M 1/67

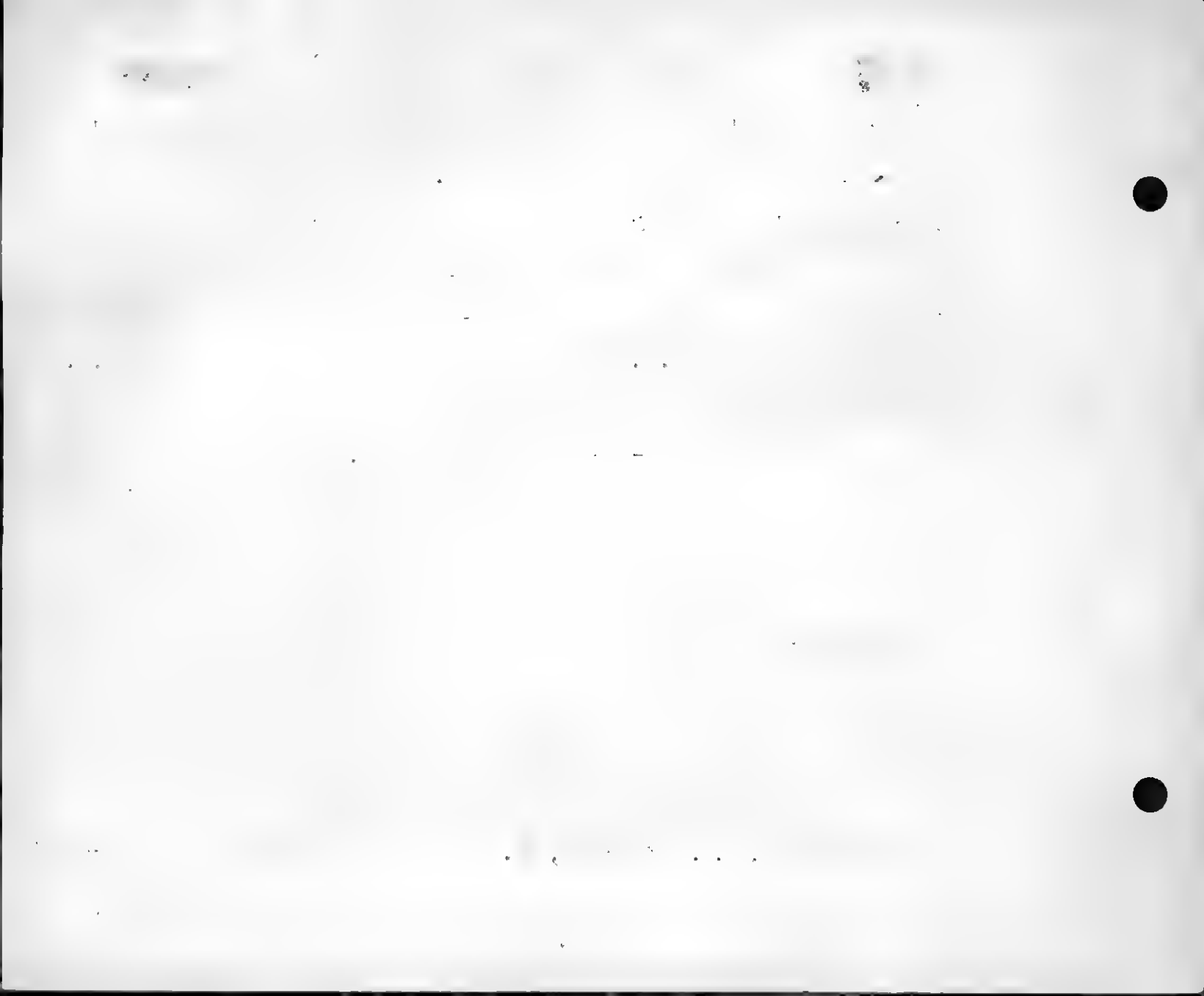
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04041

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04040

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b DOA		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4203 Russell Avenue e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard Luther Dove		4. DATE OF DEATH Month 3 Day 30 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1894
9. AGE (In years lost birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Smith		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-10-8410	
17. INFORMANT Mrs. Sadie F. Dove (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes unknown		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 5 yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 3-31-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/1/67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.	23d. LOCATION (City or town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nalley's Inc.		25a. REC'D BY REGISTRAR APR 3 1967	
ADDRESS Maryland Rainier		25b. REGISTRAR'S SIGNATURE Charles Judge	

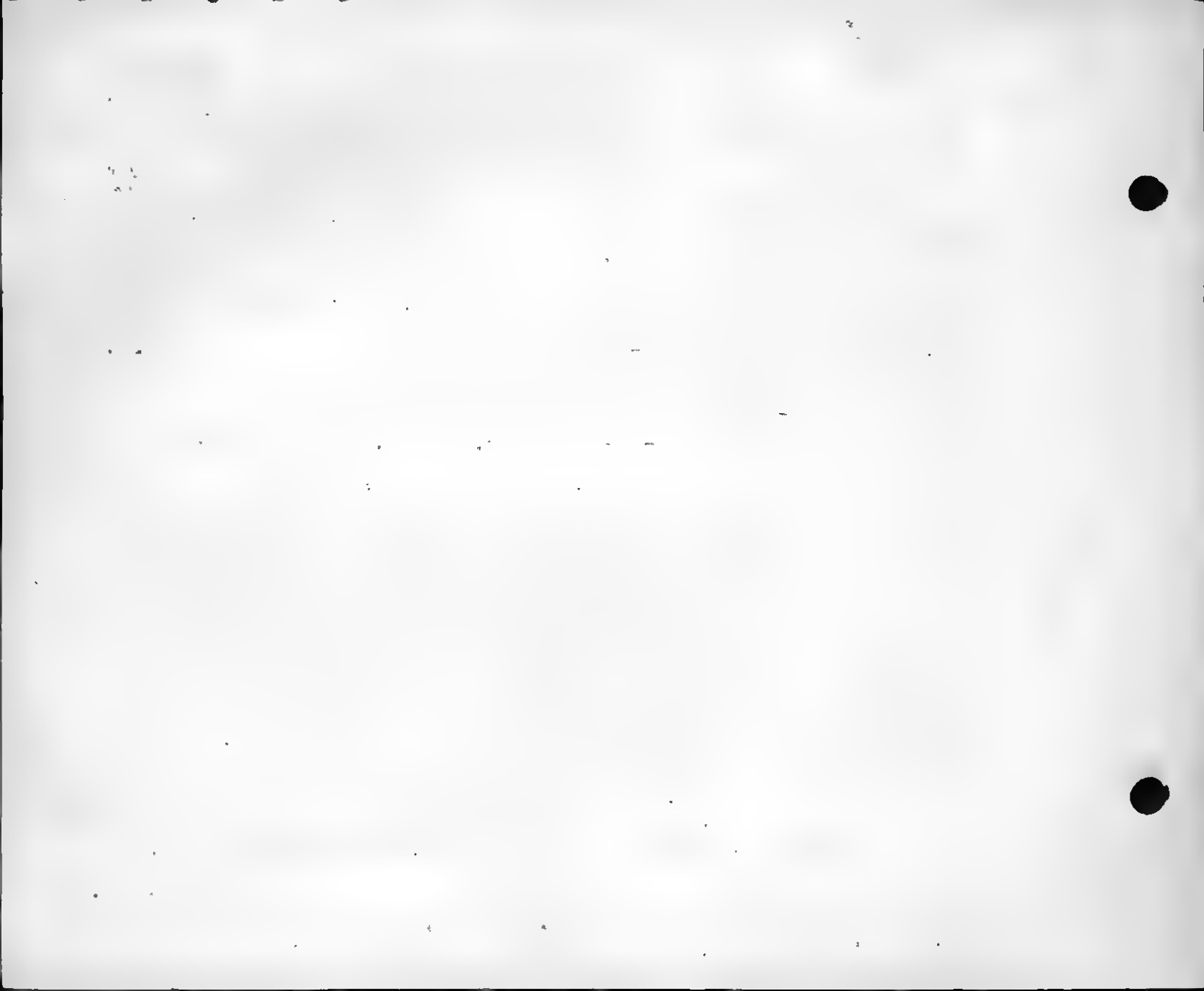


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS 12702 Beaverdale Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edna W. Dunaway						4. DATE OF DEATH Month March Day 13 Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 Sept., 1928		9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months 3 Days 9 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George A. Whitely						14. MOTHER'S MAIDEN NAME Jeanette Balian					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 219-22-6198		17. INFORMANT Mr. Carl W. Dunaway (above address)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism & Pul. Infarction (b) Left lower lobe (c) Pulmonary Carcinoma Lt. upper lobe - 9 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. metastases to Brain Lt side, & post thoracic wall Lt & Rt side 6 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulm. Pulmonary edema											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MAY 1966 , to MARCH 13, 1967 , that (I) (we) last saw the deceased alive on MARCH 13, 1967 , and that death occurred at 11:30 PM from the causes and on the date stated above.											
22a. SIGNATURE Norman K. Bohrer						22b. DATE SIGNED MARCH 14, 1967		22c. PHYSICIAN'S NAME (Type) Norman K. Bohrer, M.D.			
22d. ADDRESS 3231 Superior Lane, Bowie, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town or county) (State) Colmar Manor, Md.			
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.						25a. REC'D BY REGISTRAR MAR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

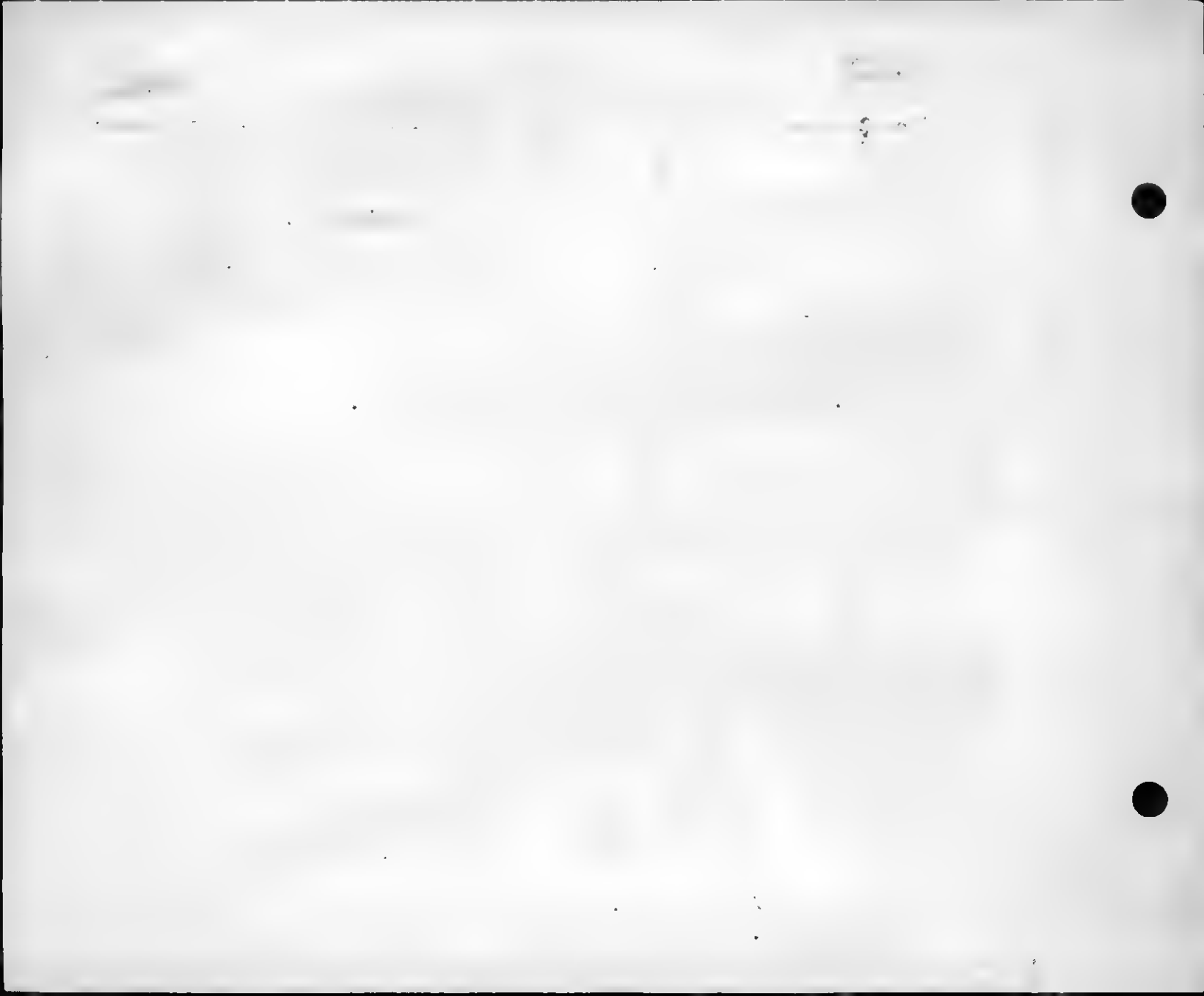
04043

CERTIFICATE OF DEATH

04042

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr.15 mins	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 7809 Giddings Dr.	
3 NAME OF DECEASED (Type or print) First Elsie C. Middle Duran Last Duran		4. DATE OF DEATH Month March Day 28 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1919 7/12/18
9. AGE (In years lost birthday) 48 yrs.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME WALTER B. TIPPETT		14. MOTHER'S MAIDEN NAME MAUDE A. CUMES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		17. INFORMANT Address PETER DURAN SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Bilateral DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Pulmonary Edema, Bilateral			INTERVAL BETWEEN ONSET AND DEATH 1 Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 24, 1967, to March 24, 1967, that (I) (we) last saw the deceased alive on March 24, 1967, and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE William Brainin M.D.		22b. DATE SIGNED 3/29/67	
22c. PHYSICIAN'S NAME (Type) WM BRAININ		22d. ADDRESS 6124 Central Ave, Capital Hghl 2d	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/1/67	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. RECD BY REGISTRAR MAR 31 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

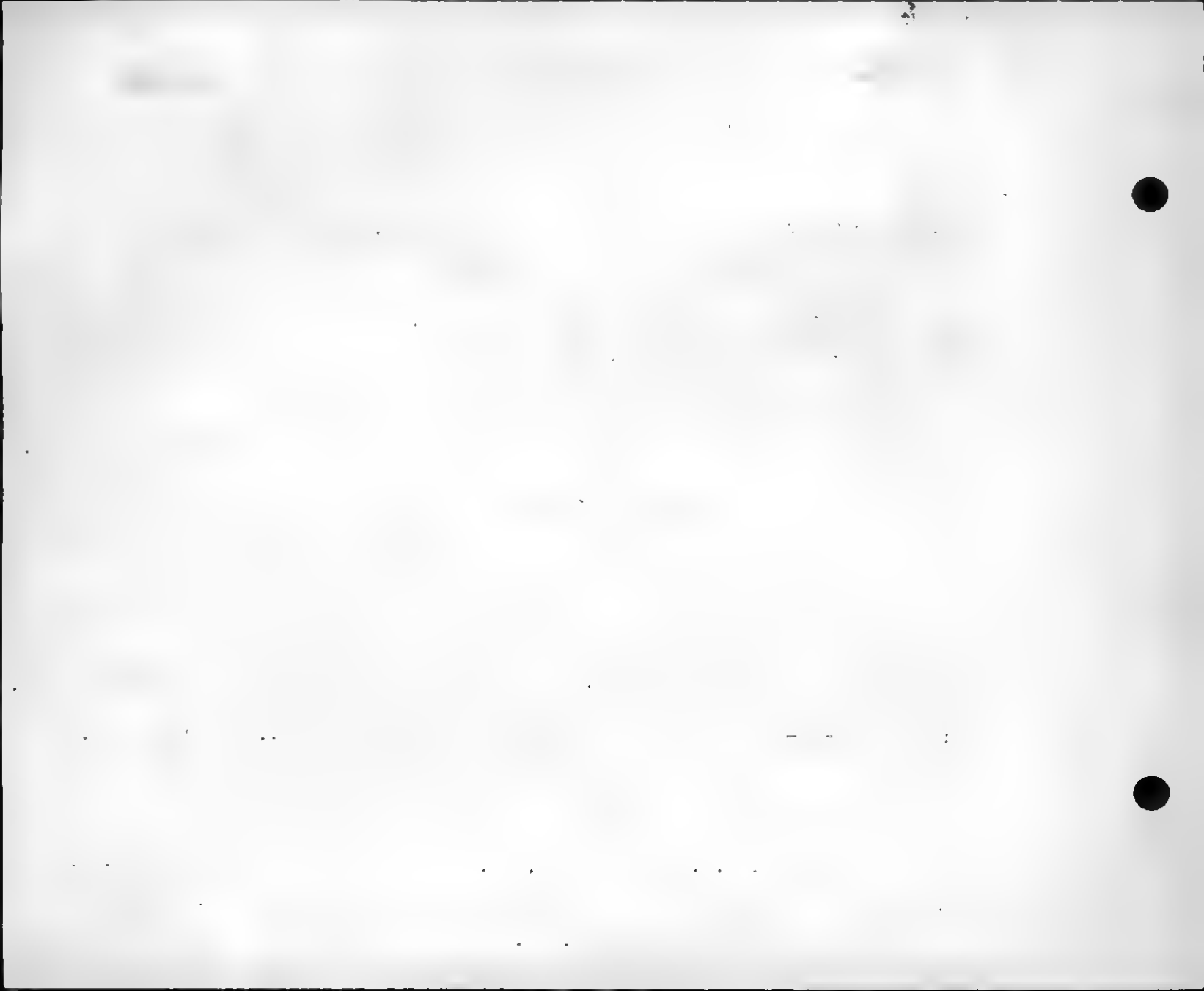
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04044

04043

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c LENGTH OF STAY N to DOA DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Norman Edwards		4 DATE OF DEATH Month Day Year 3 21 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10 Jan. 1938
9 AGE (in years lost birthday) 29 yrs		F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Express Co	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Norman L. Edwards		14 MOTHER'S MAIDEN NAME Lucy V Nevitt	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes		16 SOCIAL SECURITY NO 220 34 4673	
17 INFORMANT Linda D Edwards		Address Hillcrest Heights, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in car which went out of control and hit a tree.	
20c TIME OF INJURY Month Day, Year Hour o m 4:49am 3-21- 19 67	20d INJURY OCCURRED <input checked="" type="checkbox"/> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc) 5300 block Riverdale Rd., Riverdale, Md.	
20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-21-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF March 24, 1967	23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d LOCATION (City or Town) (County) (State) Colmar Manor, Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.		25a RECD BY REGISTRAR Charles Judge 25b REGISTRAR'S SIGNATURE Charles Judge	



CERTIFICATE OF DEATH

Reg. Dist. No. 04044

04045

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4914 Porter Ave.</u>		d. STREET ADDRESS <u>4914 Porter Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>EMMONS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1868</u>
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. of Am.</u>	

13. FATHER'S NAME <u>UNKNOWN</u> <u>Mrs. Hagen</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-46-4485</u>	
17. INFORMANT <u>Mrs. Thelma L. McGuire</u>		Address <u>4914 Porter Ave. Suitland, Md.</u>	

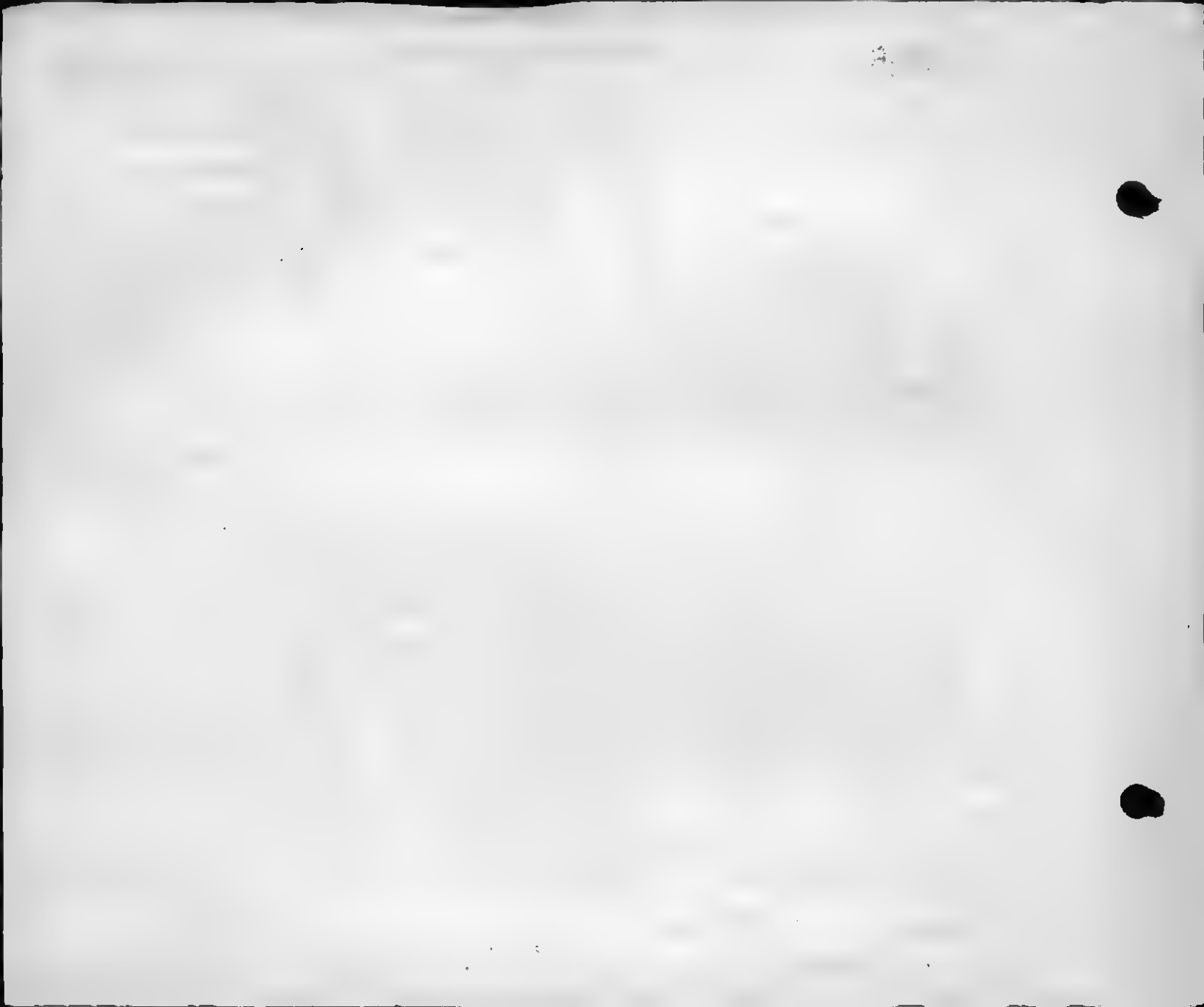
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia with resultant Anemia</u> DUE TO (c) <u>Hypertensive Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 months</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>April 6, 1965</u> to <u>March 6, 1967</u> , that I last saw the deceased alive on <u>March 5, 1967</u> , and that death occurred at <u>9:00</u> AM, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Walcutt W. Gibson</u> M.D.	ADDRESS (Street, city or town, state) <u>4300 St. Barnabas Road</u> DATE SIGNED <u>March 6, 1967</u>
PHYSICIAN'S NAME (Type) <u>Walcutt W. GIBSON</u> <u>Marlow Heights, Maryland</u> <u>20031</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 9, 1967</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Wilhelm</u>		ADDRESS <u>Suitland, Md.</u>	24a. REC'D BY REGISTRAR <u>MAR 13 1967</u>
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04046

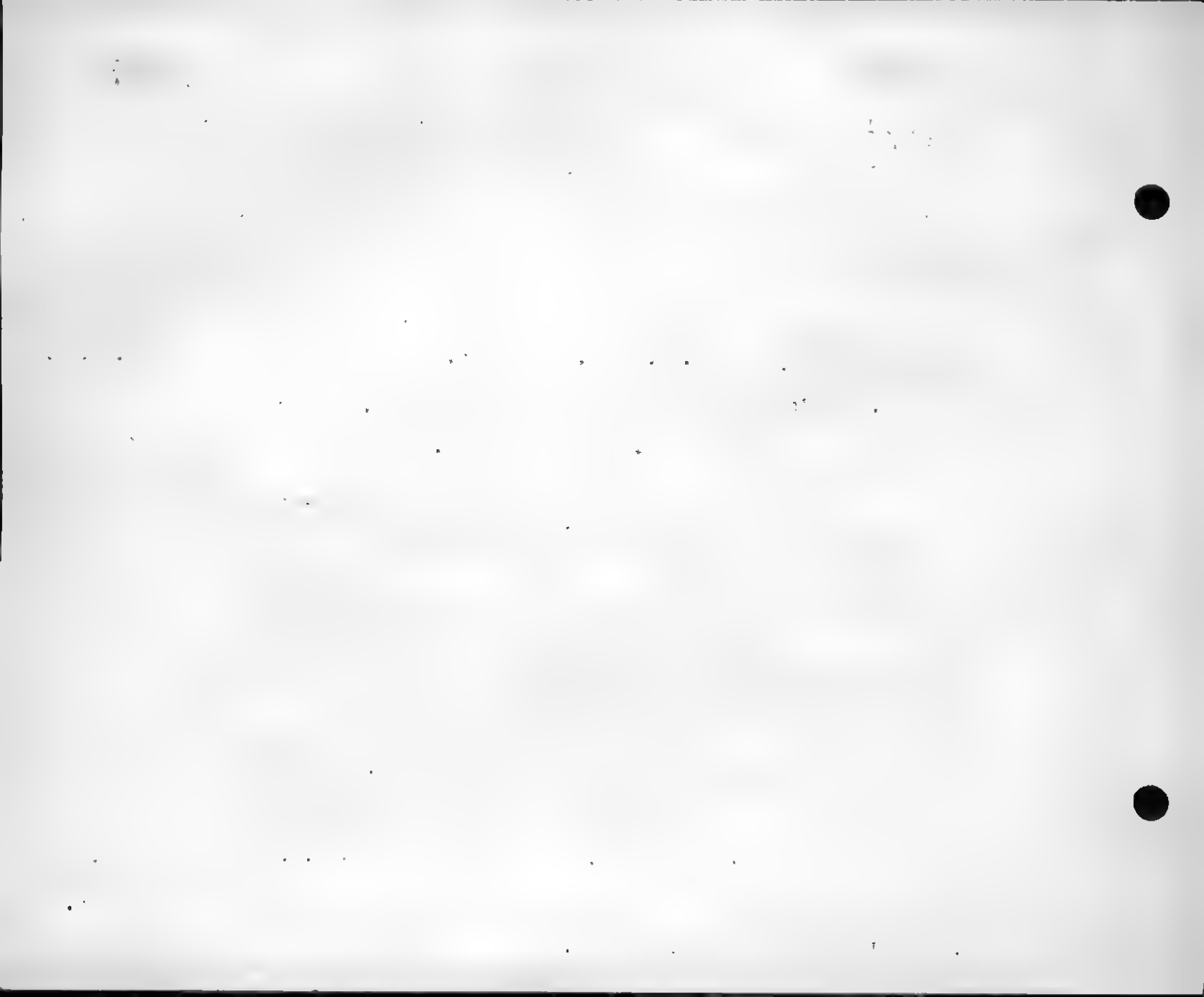
CERTIFICATE OF DEATH

04045

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 8316 Verona Drive	
3 NAME OF DECEASED (Type or print) First Middle Last Louis H English		4 DATE OF DEATH Month Day Year March 16 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Oct. 1918
9. AGE (In years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Industrial Spec.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (County & State, or foreign country) La.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George L. English		14. MOTHER'S MAIDEN NAME Caffie L. Napper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Helen J. English		Address Same as # 2 (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Coronary thrombosis DUE TO (c) Coronary arterio. heart disease			INTERVAL BETWEEN ONSET AND DEATH 7-9 hrs. 7-9 hrs. 1 yr.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 14, 19 67 to March 16, 19 67 that (I) (we) last saw the deceased alive on March 16, 1967 , and that death occurred at 5:47 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Bernard J. Walsh</i>		22b. DATE SIGNED 3/16/67	
22c. PHYSICIAN'S NAME (Type) Bernard J. Walsh, M.D.		22d. ADDRESS 1800 Eye St., N.W. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/19/67	23c. NAME OF CEMETERY OR CREMATORY Harmony Chapel Cemetery	23d. LOCATION (City or Town) (County) (State) Bubach La.
24. FUNERAL DIRECTOR F. Gasch'S Sons		25a. REC'D BY REGISTRAR MAR 17 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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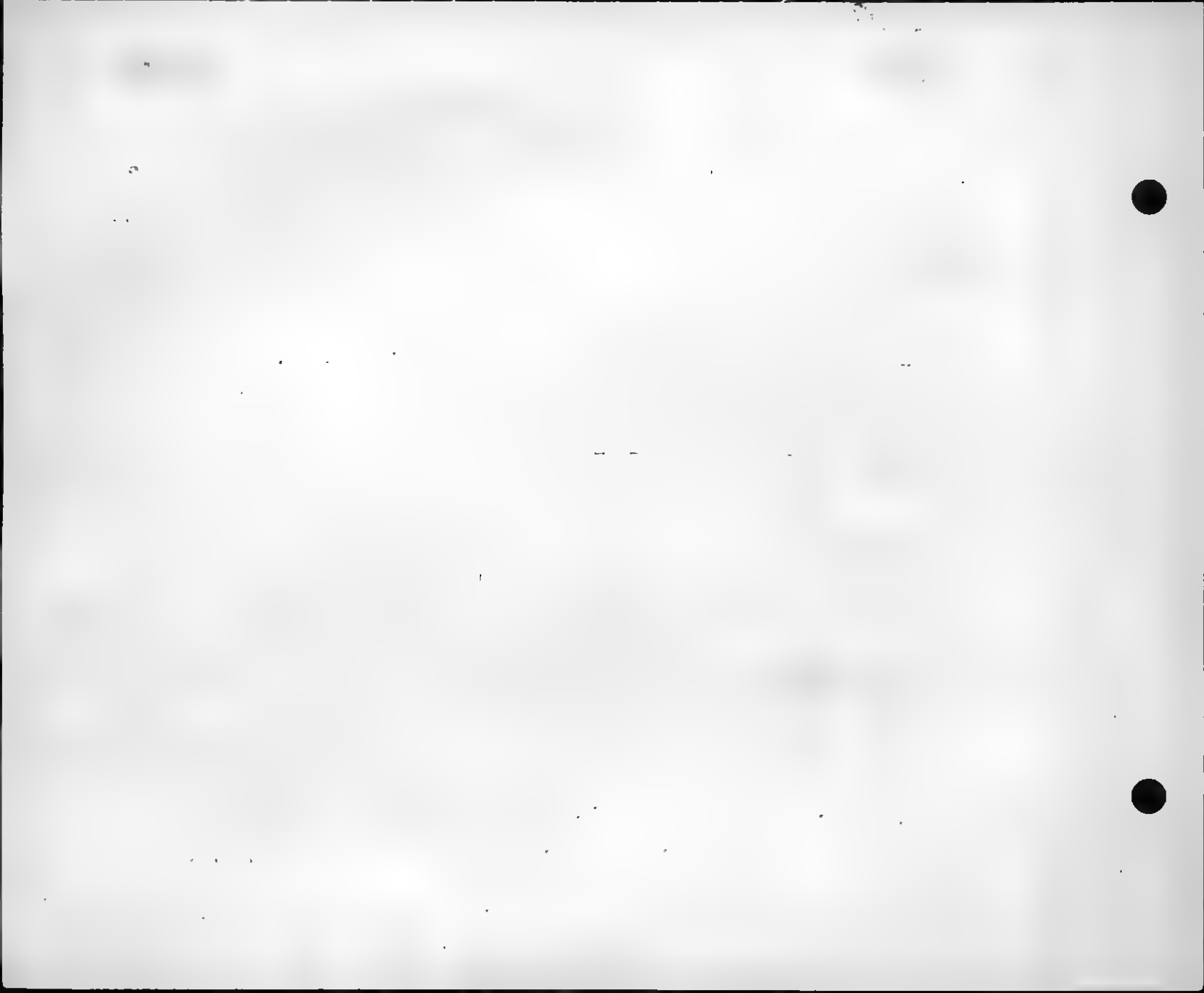
MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04047

CERTIFICATE OF DEATH

04046

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 56 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		d. STREET ADDRESS 8307 RAMMER DRIVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HAROLD JAY ESHLEMAN		4. DATE OF DEATH Month Day Year MARCH 13 19 67	
5. SEX MAL	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 MARCH 1928
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MSGT - ELISTED		10b. KIND OF BUSINESS OR INDUSTRY U.S. AIRFORCE	
11. BIRTHPLACE (County & State, or foreign country) ELIZABETHTOWN, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IRA WILLIAM ESHLEMAN		14. MOTHER'S MAIDEN NAME VIRGIE ESTHER RISSE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES SE 46-1967		16. SOCIAL SECURITY NO. 197-20-1791	
17. INFORMANT GERALDINE H. ESHLEMAN (WIFE)		Address SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO RESPIRATORY FAILURE DUE TO STAGE IV, HODGKIN'S DISEASE (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from 26 JAN , 19 67 , to 13 MARCH , 19 67 , that (I) (we) last saw the deceased alive on 23 MARCH , 19 67 , and that death occurred at 0302 M , from causes and on the date stated above.			
22a. SIGNATURE <i>Frederick Sachs</i> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 13 MARCH 1967
22c. PHYSICIAN'S NAME (Type) FREDERICK SACHS, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASH., D.C. 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/16/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL.	23d. LOCATION (City or Town) (County) (State) ARLINGTON VA.
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC		25a. REC'D BY REGISTRAR MAR 14 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04048

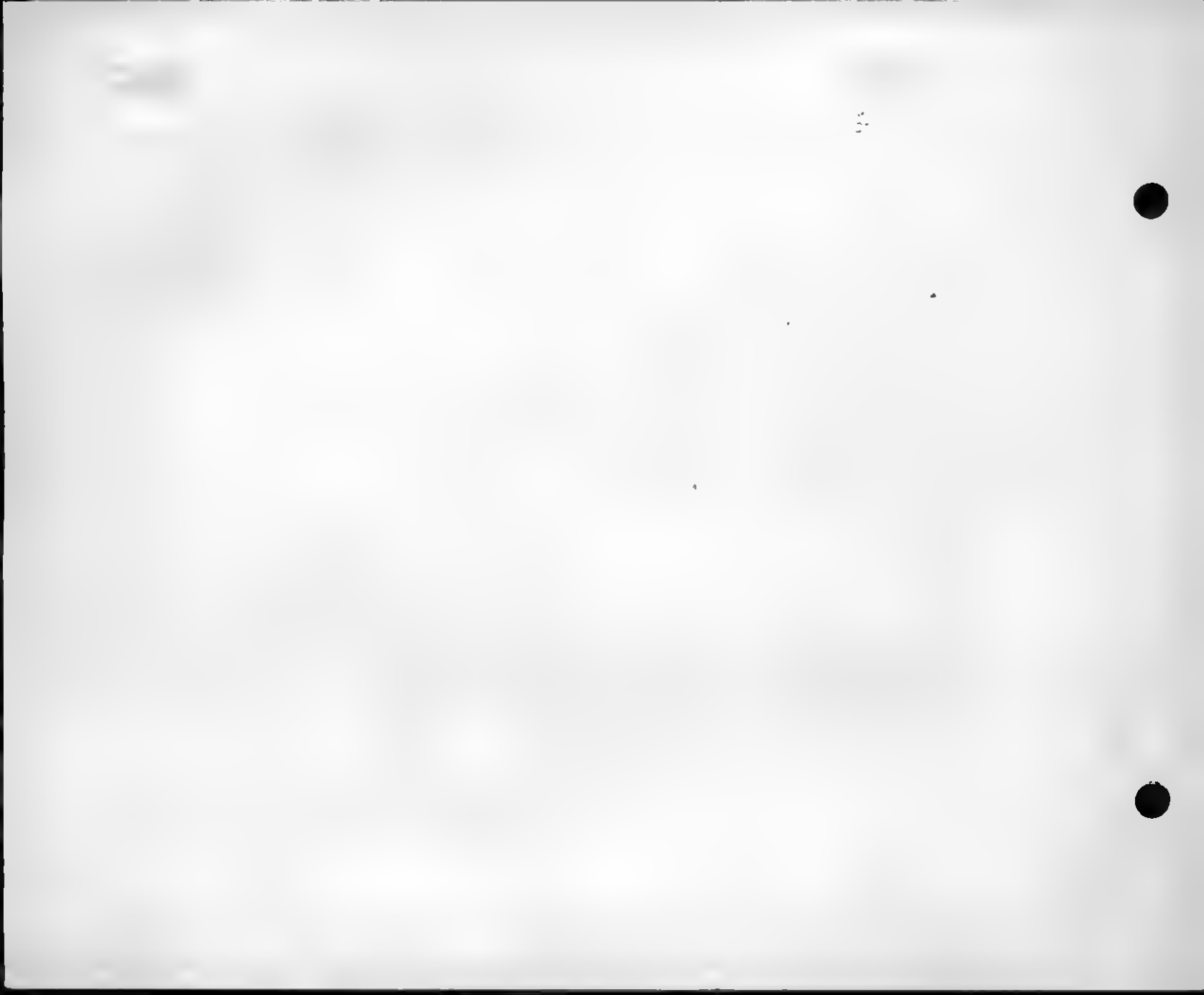
CERTIFICATE OF DEATH

04047

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1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 6 6 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 9707 Rhode Island Ave.	
3. NAME OF DECEASED (Type or print) First Bertha Middle MARIE Last Ewell		4. DATE OF DEATH Month March Day 5 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-20
9. AGE (In years lost birthday) 46 yrs		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY US A	
13. FATHER'S NAME William Olin Layton		14. MOTHER'S MAIDEN NAME Sara E. Cahill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JAMES R. EWELL.		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO cerebral edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) glioma of brain (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gastrointestinal hemorrhage			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-27 , 1967 , to 3-5 , 1967 , that (I) (we) last saw the deceased alive on 3-4 , 1967 , and that death occurred at 3-5 , 1967 , from causes and on the date stated above.			
22a. SIGNATURE Ruth Kerr Jakoby MD		22b. DATE SIGNED Mar-6-67	
22c. PHYSICIAN'S NAME (Type) Ruth Kerr Jakoby		22d. ADDRESS 6408 Landover Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9 MARCH 1967	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM	23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND
24. FUNERAL DIRECTOR W.W. CHAMBERS Co.		25a. REC'D BY REGISTRAR MAR 8 1967	
ADDRESS RIVERDALE, MD.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

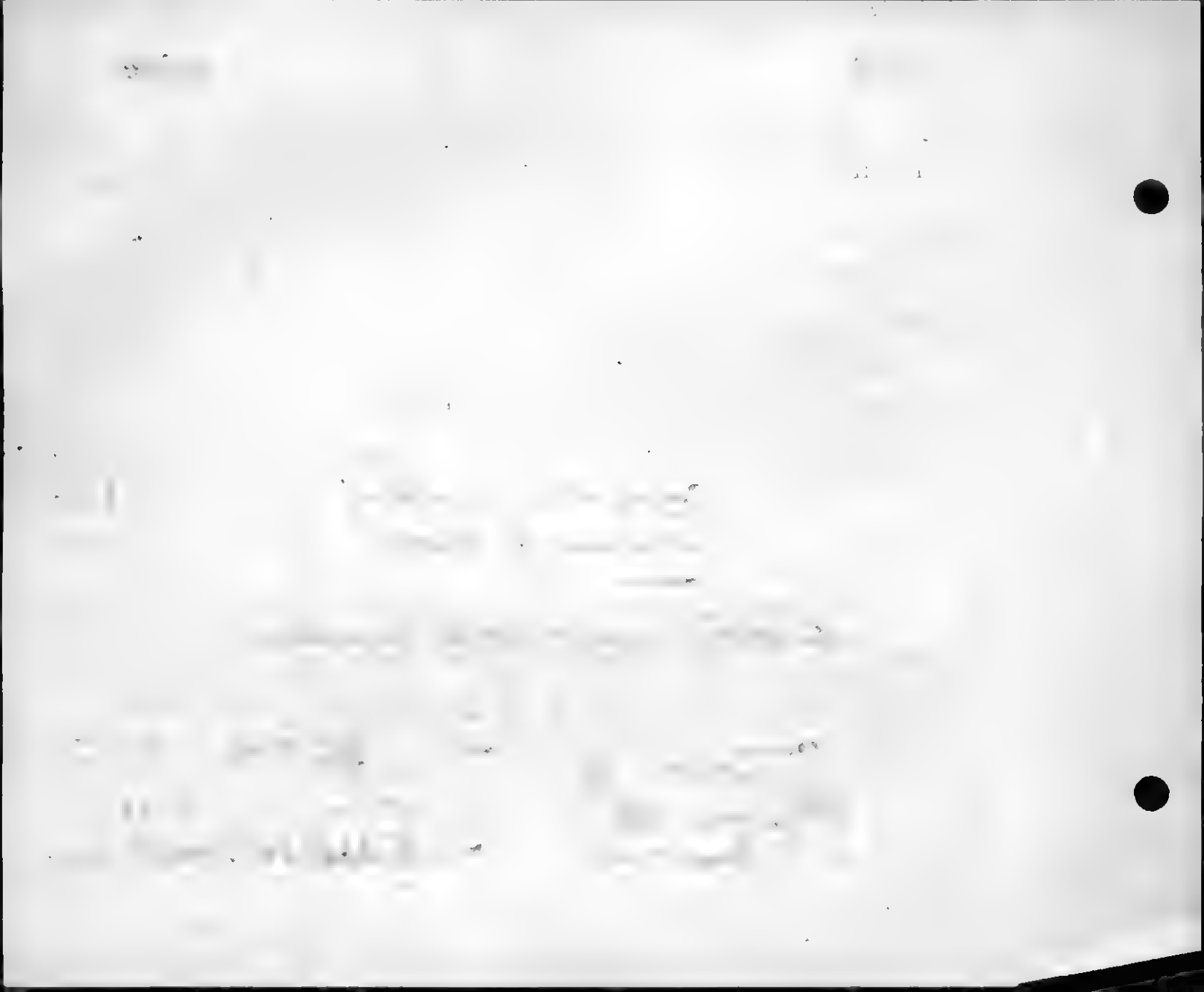
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04043

CERTIFICATE OF DEATH

04048

1. PLACE OF DEATH a. COUNTY <u>Prince Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, in institution- Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltzville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltzville Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Point Branch Nursing Home</u>		d. STREET ADDRESS <u>3120 Powdermill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>BERTHA B. FLESCHUTE</u>		4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-87</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Rabbin</u>		14. MOTHER'S MAIDEN NAME <u>unknown Sara Estes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>446-07-1739</u>	
17. INFORMANT <u>Mrs. L. Leuz</u>		Address <u>4716 Brandon Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1057</u> IMMEDIATE CAUSE (a) <u>Generalized Carcinoma of</u> DUE TO (b) <u>Carcinoma of Bowel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary anemia from hemorrhage</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>(this hospital)</u> attended the deceased from <u> </u> , 19 <u>58</u> to <u>3-26</u> , 19 <u>67</u> , that <u>(D/we)</u> lost saw the deceased alive on <u>3-22</u> , 19 <u>67</u> , and that death occurred at <u>2P</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>R.D. Bauer MD.</u>		22b. DATE SIGNED <u>3-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.D. Bauer MD</u>		22d. ADDRESS <u>2513 Duckback Rd. Oak Ridge, Tenn.</u>	
23a. BY BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>30 May 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DRUMRIGHT, TENN.</u>	23d. LOCATION (City or Town) (County) (State) <u>DRUMRIGHT, OKLAHOMA</u>
24. FUNERAL DIRECTOR <u>General Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>7400 E. Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAR 29 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

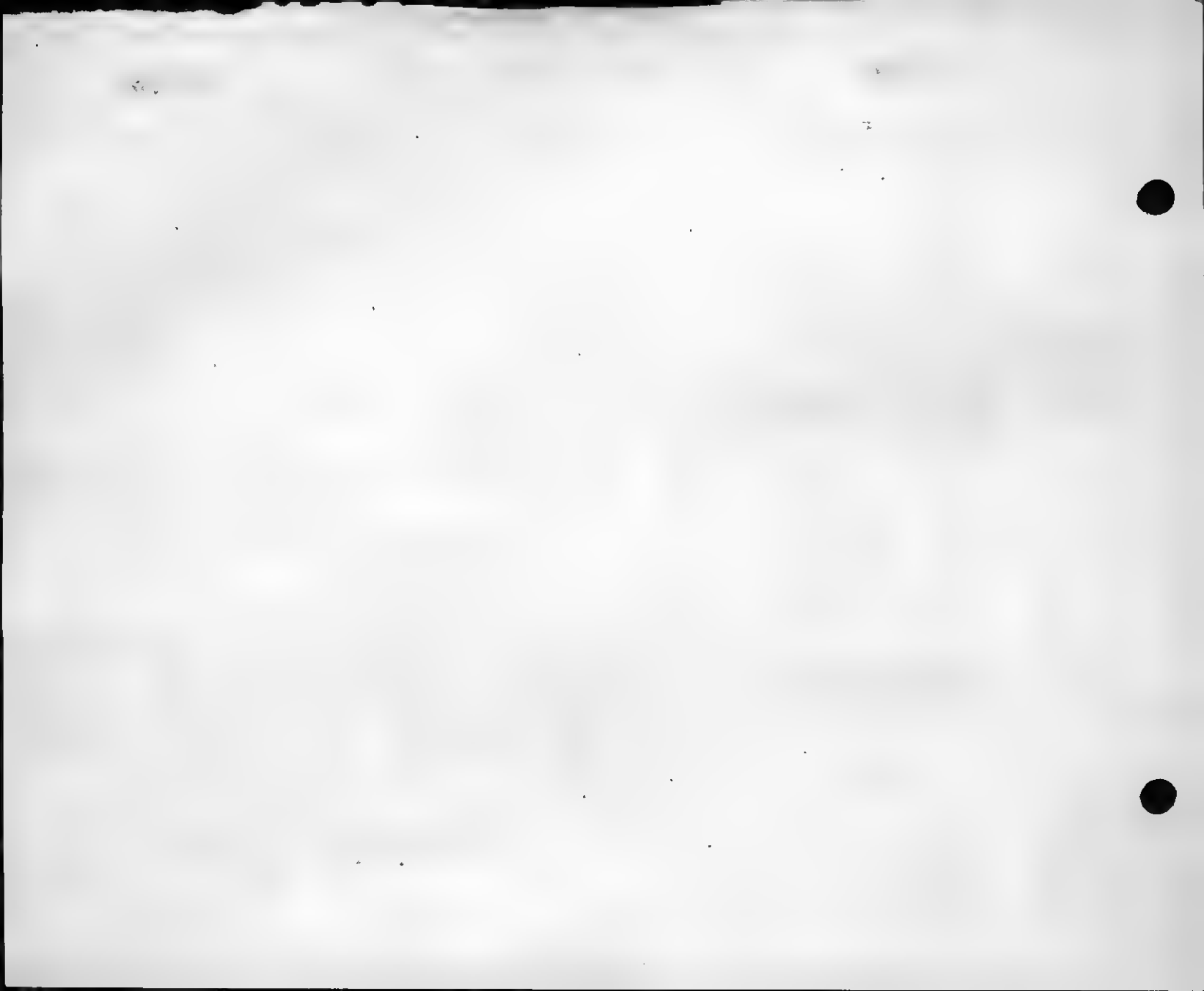
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04050

CERTIFICATE OF DEATH

04049

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL ANDREWS		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DISTRICT HEIGHTS d. STREET ADDRESS 5821 MARLBORO RD., APT 301 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JOHN ANTHONY GALLICE		4. DATE OF DEATH Month Day Year MARCH 16 19 67	
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 MARCH 1967
9. AGE (In years last birthday) yrs. 1		10. IF UNDER 1 YEAR Months Days Hours Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA	
11 BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MD.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN JOSEPH GALLICE, JR		14. MOTHER'S MAIDEN NAME ANNA MAE HORWAT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NA	
17. INFORMANT FATHER		Address SAME AS ITEM #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE DUE TO (c) CONGENITAL HEART DISEASE			
INTERVAL BETWEEN ONSET AND DEATH 1 DAY 1 DAY 1 DAY			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 19	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from 14 March, 1967 , to 16 March, 1967 , that he (we) last saw the deceased alive on 16 March 19 67 , and that death occurred at 5:10 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Michael L. Jordan</i>		22b. DATE SIGNED 16 Mar 1967	
22c. PHYSICIAN'S NAME (Type) MICHAEL L. JORDAN CAPT USAF MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB WASH DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/20/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR ROBERT E WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR 20 1967 DATE 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MD
05612

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

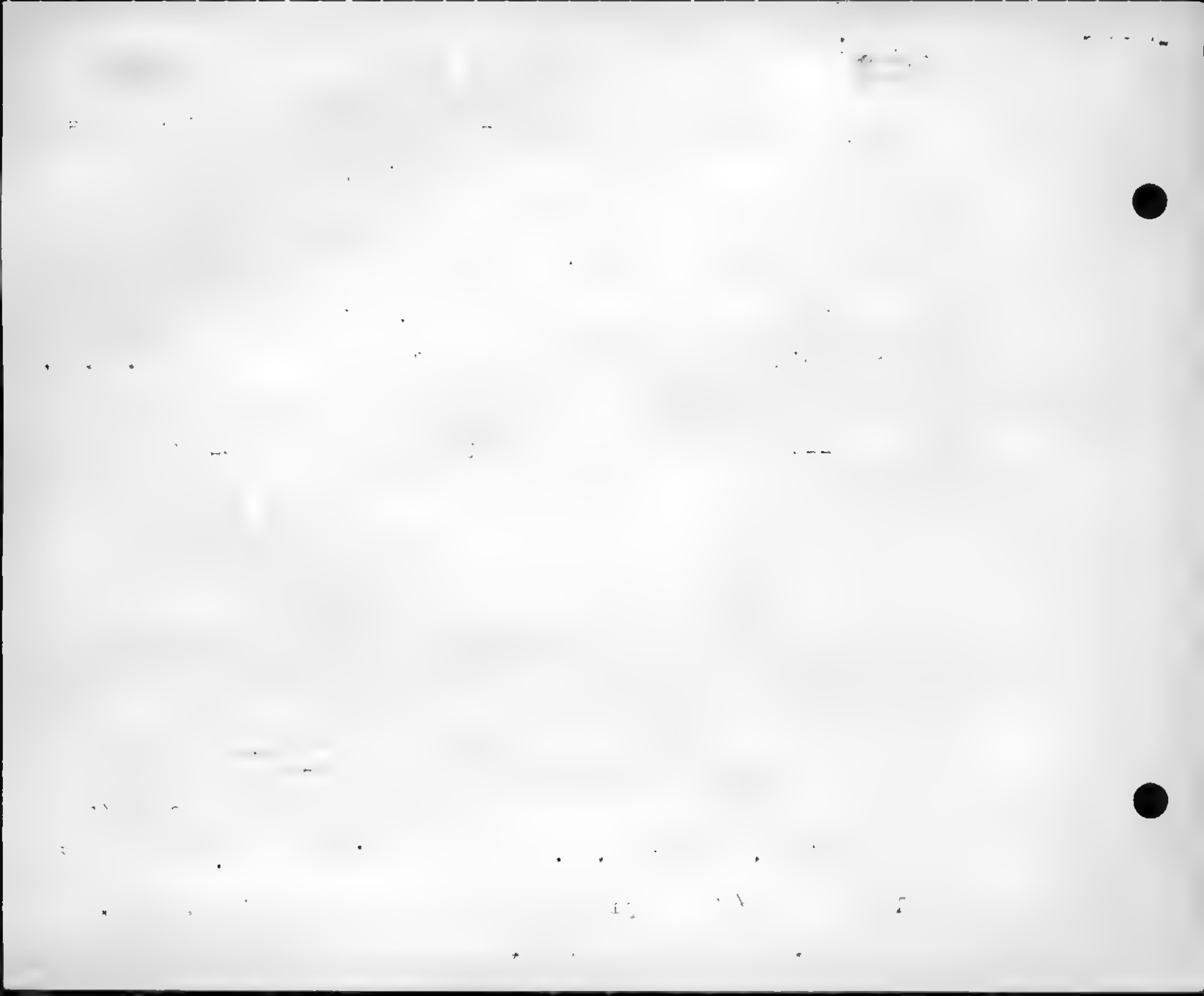
CERTIFICATE OF DEATH

05612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PrinceGeorges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY PrinceGeorges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton d. STREET ADDRESS Steed Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Eli Garner		4. DATE OF DEATH Month Day Year March 19 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 Sept., 1878
9. AGE (In years lost birthday) 88 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Tenant	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Robert Garner		14. MOTHER'S MAIDEN NAME Mary Zora Rawlings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Bertie Virginia Garner- #2		Address Same as Item	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Smile Pulmonary Edema, Bilat 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CANCE of EXT + lat. Auditory canal w/ (c) metastasis to lungs and		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Smile Bilat Pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from March 9, 1967 , to March 19, 1967 , that (I) (we) last saw the deceased alive on March 19, 1967 , and that death occurred at 5:30 AM from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen M.D.		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M. D.		22d. ADDRESS Pr. Geo General Hospital, Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/22/67	23c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery	23d. LOCATION (City or Town) (County) (State) Forestville, Md.
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR APR 12 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME 15
6M 1/67

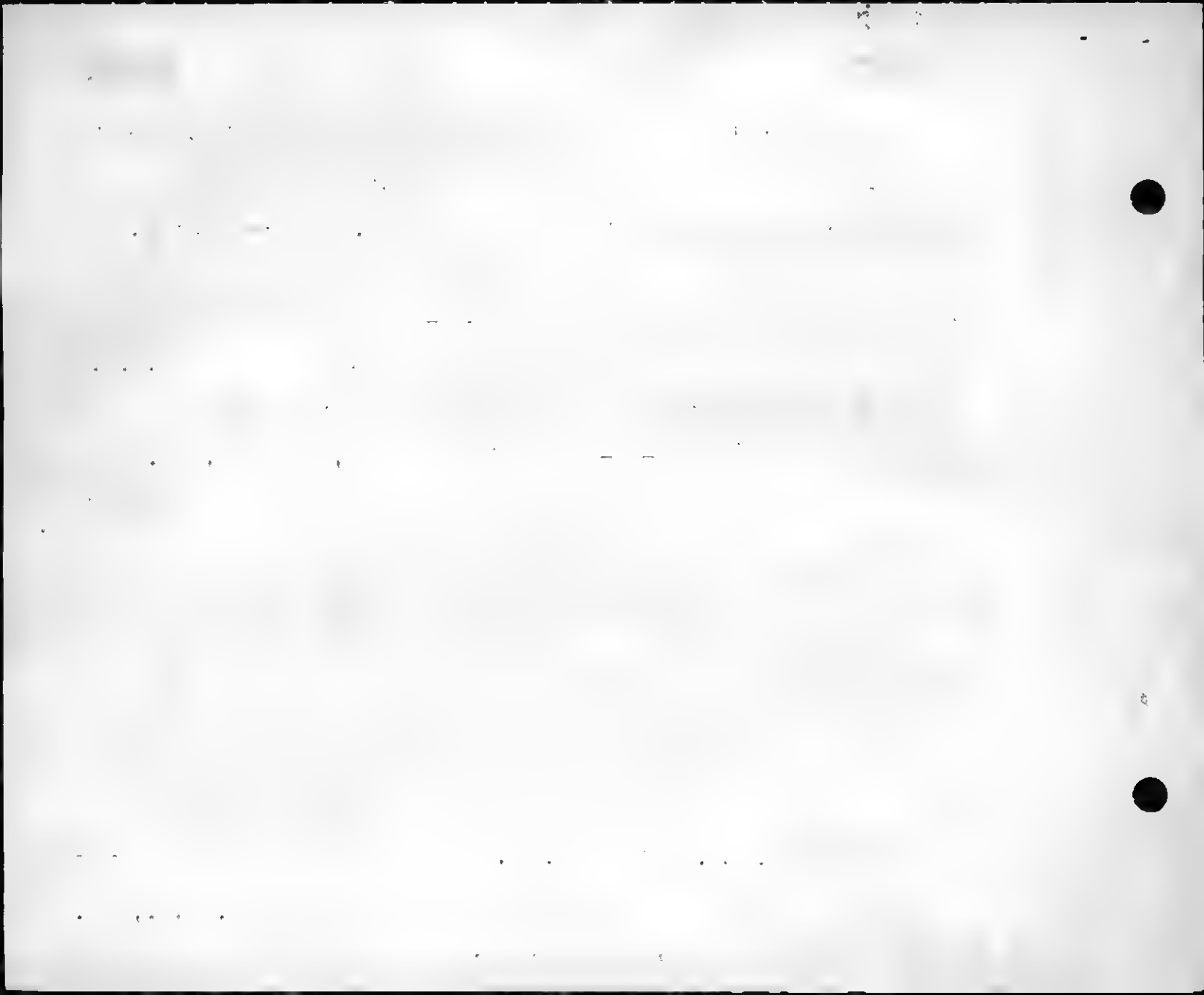
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04051

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04050

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived) f institution Res dence before adm ssion) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN Tb DOA			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e STREET ADDRESS Box 23, Rt. 1, Aquasco Neck Rd.			
3 NAME OF DECEASED (Type or print) First Middle Last George Cardinal Gibbons				4 DATE OF DEATH Month Day Year 3 22 19 67			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-21-1898	9 AGE (In years lost birthday) 68 yrs	IF UNDER 1 YEAR Months Days Hours Min		F UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life even retired) Farmer			10b KIND OF BUSINESS OR INDUSTRY Tobacco		11 BIRTHPLACE (State or foreign country) Maryland		2 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Lloyd Gibbons				14. MOTHER'S MAIDEN NAME Price Susanna DeMarr			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO 213-38-3257		17 INFORMANT Rt 1 Address Box 23 Edith Gibbons, Aquasco, Md. 20608		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes over 3 yrs.							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 3-23-67			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-25-67		23c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery		23d. LOCATION (City or Town) (County) (State) Aquasco, P.G., Md.	
24 FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.				25a REC'D BY REG-TRAR MAR 27 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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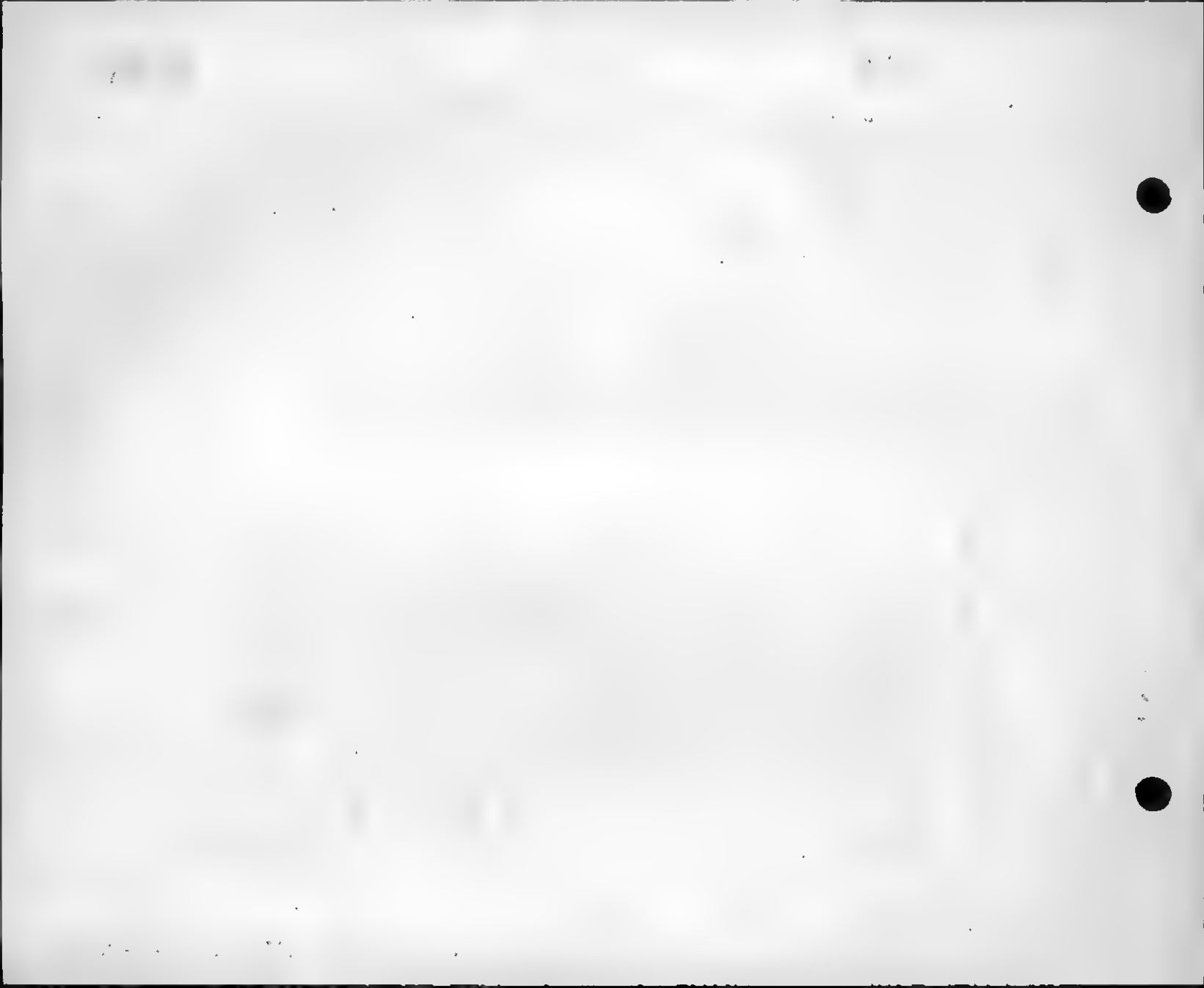
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04052

CERTIFICATE OF DEATH

04051

1. PLACE OF DEATH a. COUNTY <u>PR. GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Winton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine View Gardens Care Ctr</u>		d. STREET ADDRESS <u>191-89th AVE, LANDOVER MD</u>	
3. NAME OF DECEASED (Type or print) <u>ELLA E GIBSON</u>		4. DATE OF DEATH <u>MARCH 30 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/98</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (County & State or foreign country) <u>RED SPRING MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.B.</u>	
13. FATHER'S NAME <u>WILL MCNEEL</u>		14. MOTHER'S MAIDEN NAME <u>ANN CAMPBELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>—</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cardiovascular disease</u> DUE TO (c) <u>Atherosclerosis advanced</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-1</u> , 19 <u>67</u> , to <u>3-30</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>3-30</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>Pine View Gardens, Winton, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 3rd 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>7601- Sheriff Rd. Maryland</u>
24. FUNERAL DIRECTOR <u>Washington Funeral Chapel</u>		25a. REC'D BY REGISTRAR <u>DATE APR 7 1967</u>	
ADDRESS <u>475- H St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/67

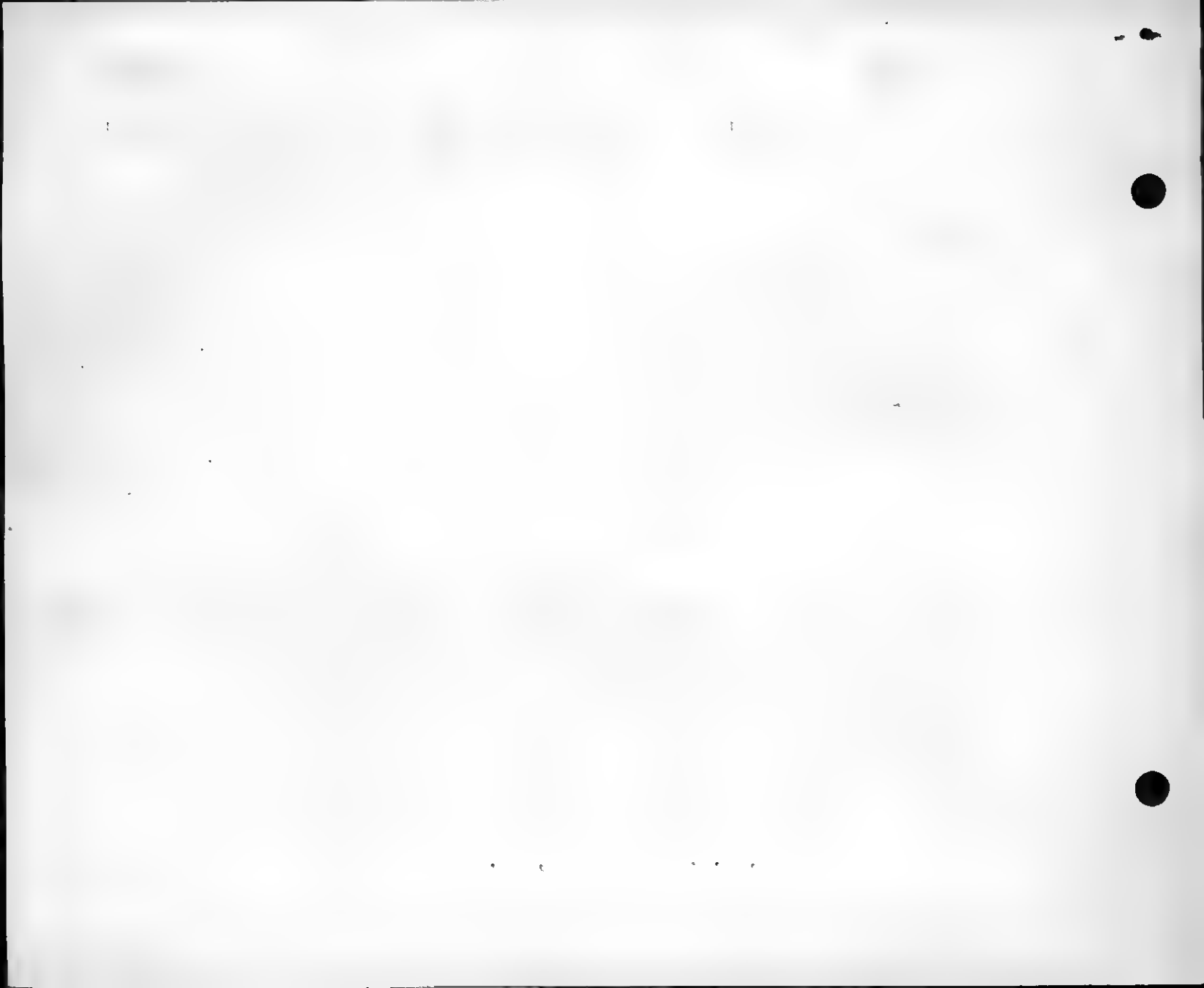
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04053

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04052

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c LENGTH OF STAY IN b 4 yrs	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 Laurel Manor Court		d STREET ADDRESS 6 Laurel Manor Court	
3 NAME OF DECEASED (Type or print) First Middle Last Florentine Maude Gilbert		4 DATE OF DEATH Month Day Year 3 9 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 30 July 1889
9 AGE (In years lost birthday) 77 yrs		10 IF UNDER 1 YEAR Months Days Hours Min 16 1	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household		10b KIND OF BUSINESS OR INDUSTRY Farmington, MAINE	
11 BIRTHPLACE (State or foreign country) MAINE		12 CITIZEN OF WHAT COUNTRY USA	
13 FATHER'S NAME CHARLES E KEITH		14 MOTHER'S M A D E N NAME JENNIE METCALF	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16 SOCIAL SECURITY NO 161-12-7014	
17 INFORMANT MR HERBERT C GILBERT, LAUREL, MD		Address 1065 5th St	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-10-67	
23a BURIAL, CREMATION, or other disposal CREMATION		23b DATE THEREOF MAR. 11, 1967	
23c NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d LOCATION (City or town) (County) (State) WASH. D.C.	
24 FUNERAL DIRECTOR Harold S. WAOE, LAUREL, MARYLAND		25a READ BY REGISTRAR DATE MAR 14 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

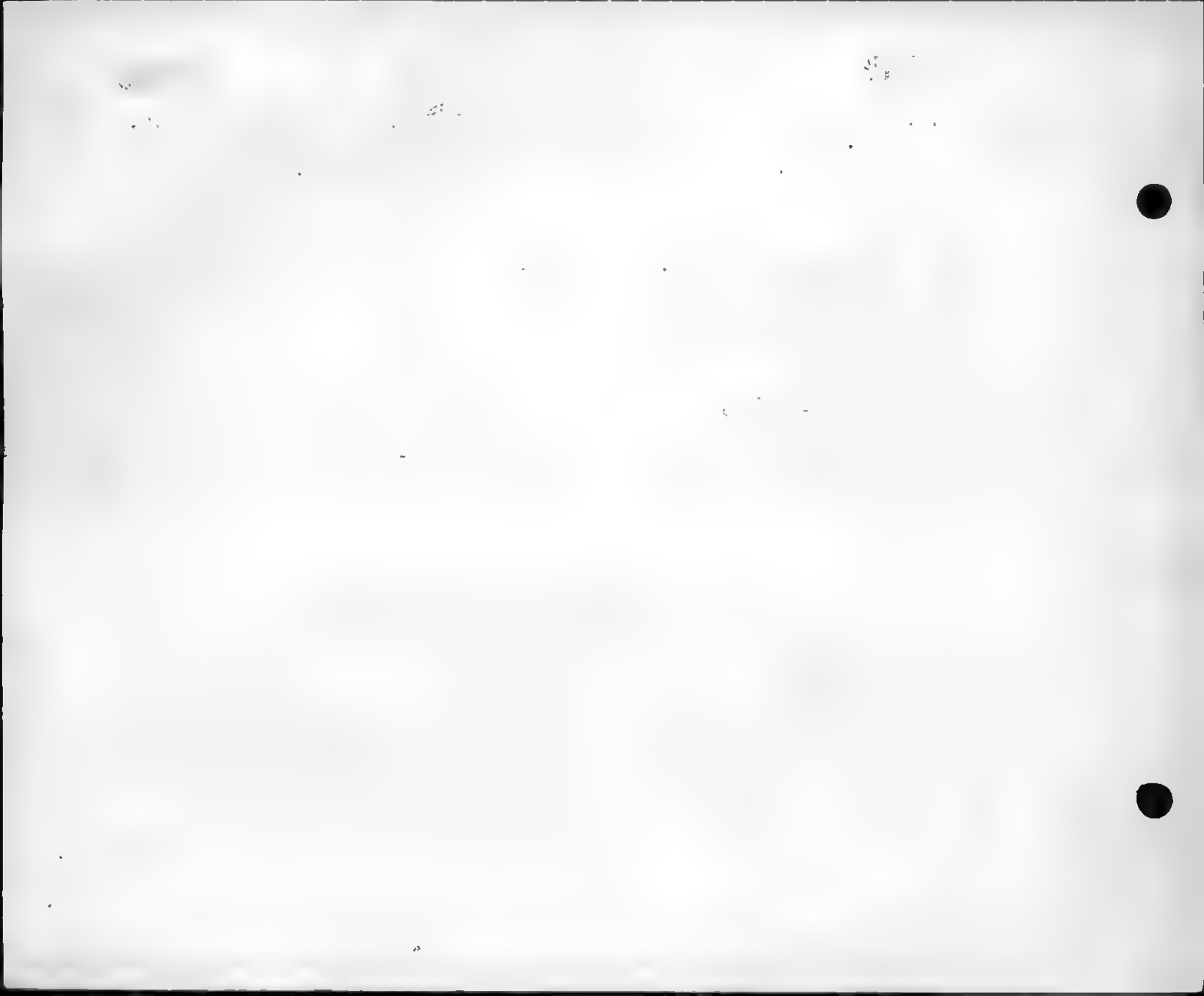
04054

CERTIFICATE OF DEATH

04053

1 PLACE OF DEATH a. COUNTY <u>P.G.</u> County <u>Riverdale</u> <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Md.</u> b COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Md.</u>		c. LENGTH OF STAY IN 1b <u>1 Day-</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leland Hospital</u>		d. STREET ADDRESS <u>11338 Cherry Hill, Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Goldberg, Mrs. Sarah,</u>		4 DATE OF DEATH Month <u>3-</u> Day <u>19</u> Year <u>19 67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-15-88</u>
9 AGE (In years lost, birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Bernhard Finkelstine,</u>		14. MOTHER'S MAIDEN NAME <u>Cecilia Roeschman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Eugene Leland Hospital,</u>		Address <u>4408 Queensbury Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4200 Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>General arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchial Pneumonia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Mar 18, 1967</u> to <u>Mar 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 19, 1967</u> , and that death occurred at <u>12:00</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>L.W. Malin</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>L.W. MALIN M.D.</u>		22d. ADDRESS <u>Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden Falls Church, Va.</u>	23d. LOCATION (City or town) (County) (State)
24 FUNERAL DIRECTOR <u>Bernard Danzansky & Sons Washington DC</u>		25a. REC'D BY REG. STRAR <u>MAR 23 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

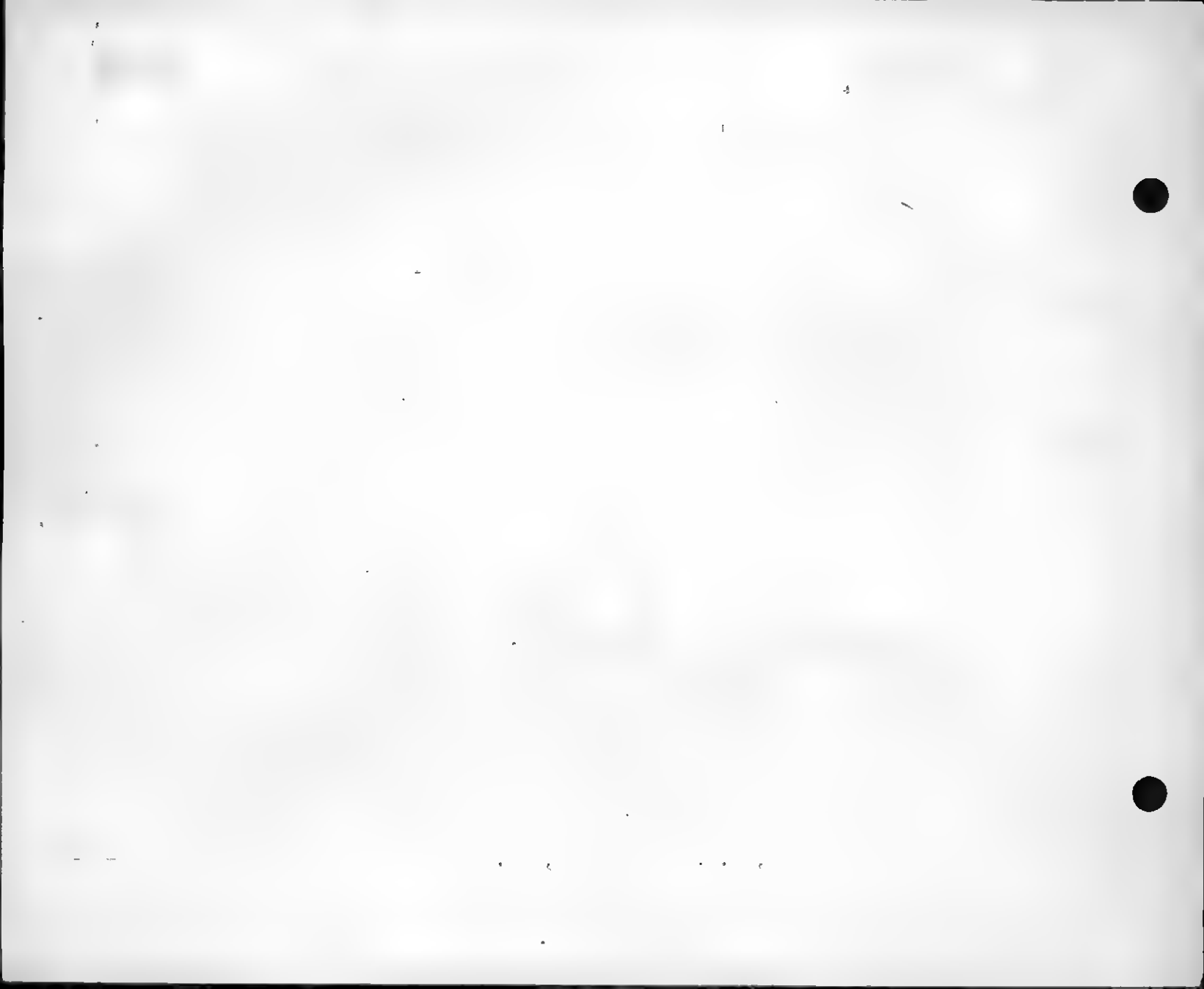
04055

04054

FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 15 DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Ieland Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ralph Franklin Gordon Sr.				4. DATE OF DEATH Month 3 Day 21 Year 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 April 1909	
9. AGE (In years lost birthday) 57 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired D C Fireman		10b. KIND OF BUSINESS OR INDUSTRY D C Government		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME William F Gordon			
14. MOTHER'S MAIDEN NAME Fannie Potter				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, if unknown) If yes give war or dates of service) no			
16. SOCIAL SECURITY NO 578 10 5480				17. INFORMANT Ruth L. Gordon Address Chillum, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aleukemic leukemia - over 3 months.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B)			
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home farm factory street office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. M.D.				22. DATE SIGNED 3-22-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town or county) Winston Salem North Carolina			
23a. BURIAL CREMATION Burial		23b. DATE THEREOF Mar 24, 1967		23. NAME OF CEMETERY OR CREMATOR Salem Cemetery		23d. LOCATION (City or town) (County) (State) Winston Salem North Carolina	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE MAR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-105. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

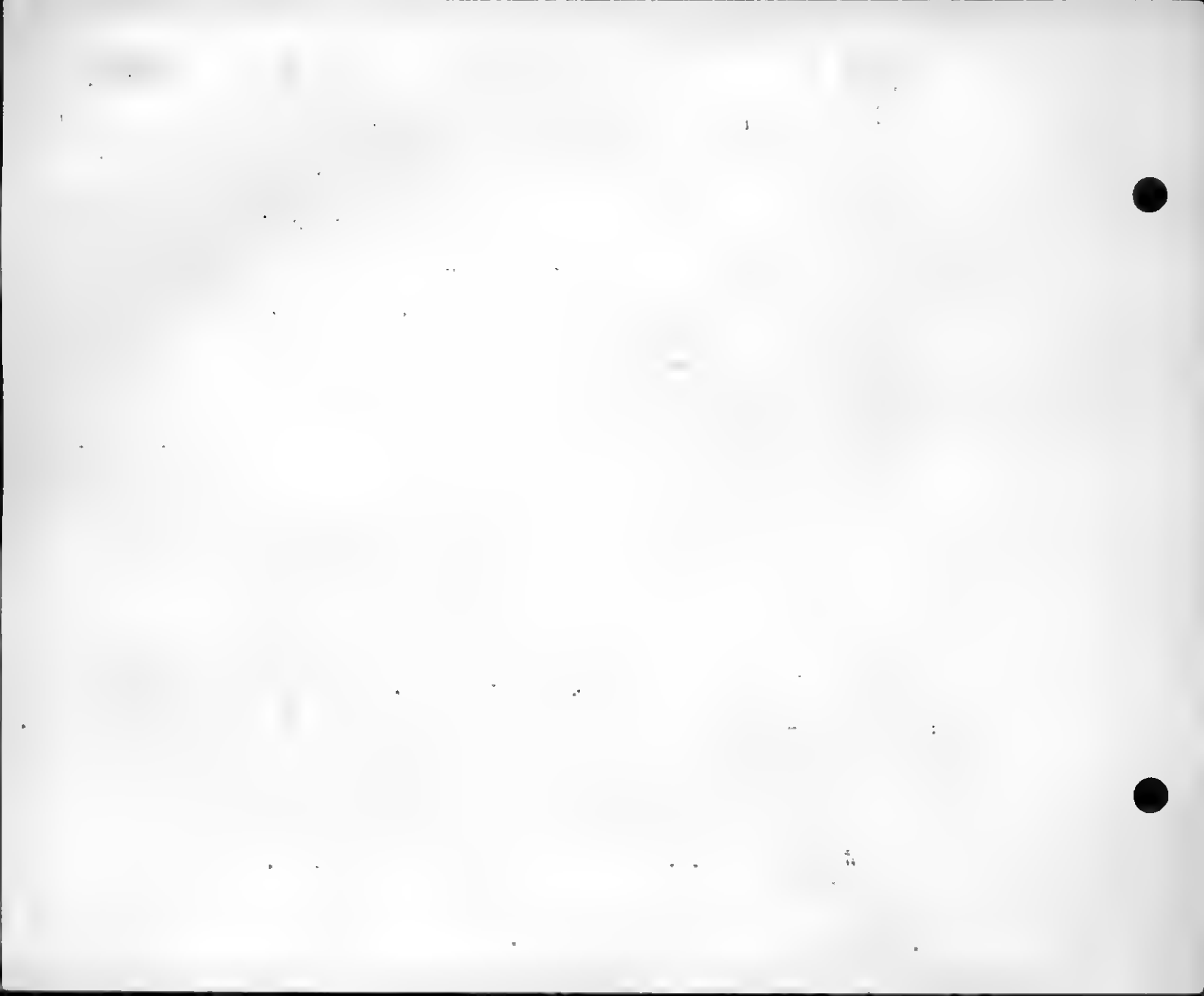
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04056

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04055

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park				c. LENGTH OF STAY IN b 16-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9223 B altimore Avenue				d. STREET ADDRESS 9223 Baltimore Avenue			
3 NAME OF DECEASED (Type or print) First Middle Last Joseph Bernard Graf				4 DATE OF DEATH Month Day Year March 3 19 67			
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 15, 1894	
9 AGE (In years last birthday) 72 yrs		10a USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) Salesman		10b KIND OF BUSINESS OR INDUSTRY Gift shop		9 AGE (In years last birthday) 72 yrs	
11 BIRTHPLACE (State or foreign country) Ohio				12 CITIZEN OF WHAT COUNTRY? U S A			
13 FATHER'S NAME Bernard Graf				14 MOTHER'S MAIDEN NAME Oglesby			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 269 12 7238		17. INFORMANT Blanche E Graf Address College Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive polmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phlebo-thrombosis of right femoral vein DUE TO (c) Immobilization of leg in cast INTERVAL BETWEEN ONSET AND DEATH minutes over 24 hrs 7 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell, in hotel room.							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Fell, in hotel room.			
20c TIME OF INJURY Month, Day, Year 9:30AM 1-14-67				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, etc.) Penn-Sheraton Hotel	
20f (City or town) Pittsburg				20g (County) Pa.		20h (State) Pa.	
21 I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe				22. DATE SIGNED 3-4-67			
EXAMINER'S NAME (Type) John Kehoe, M.D.				Address Riverdale, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF March 7, 1967		23c NAME OF CEMETERY OR PLACE OF BURIAL Rose Hill Burial Park		23d LOCATION (City or Town) (County) (State) Akron Summit Ohio	
24 FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.			
25a REC'D BY REGISTRAR MAR 7 1967				25b REGISTERED BY John Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove caption papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

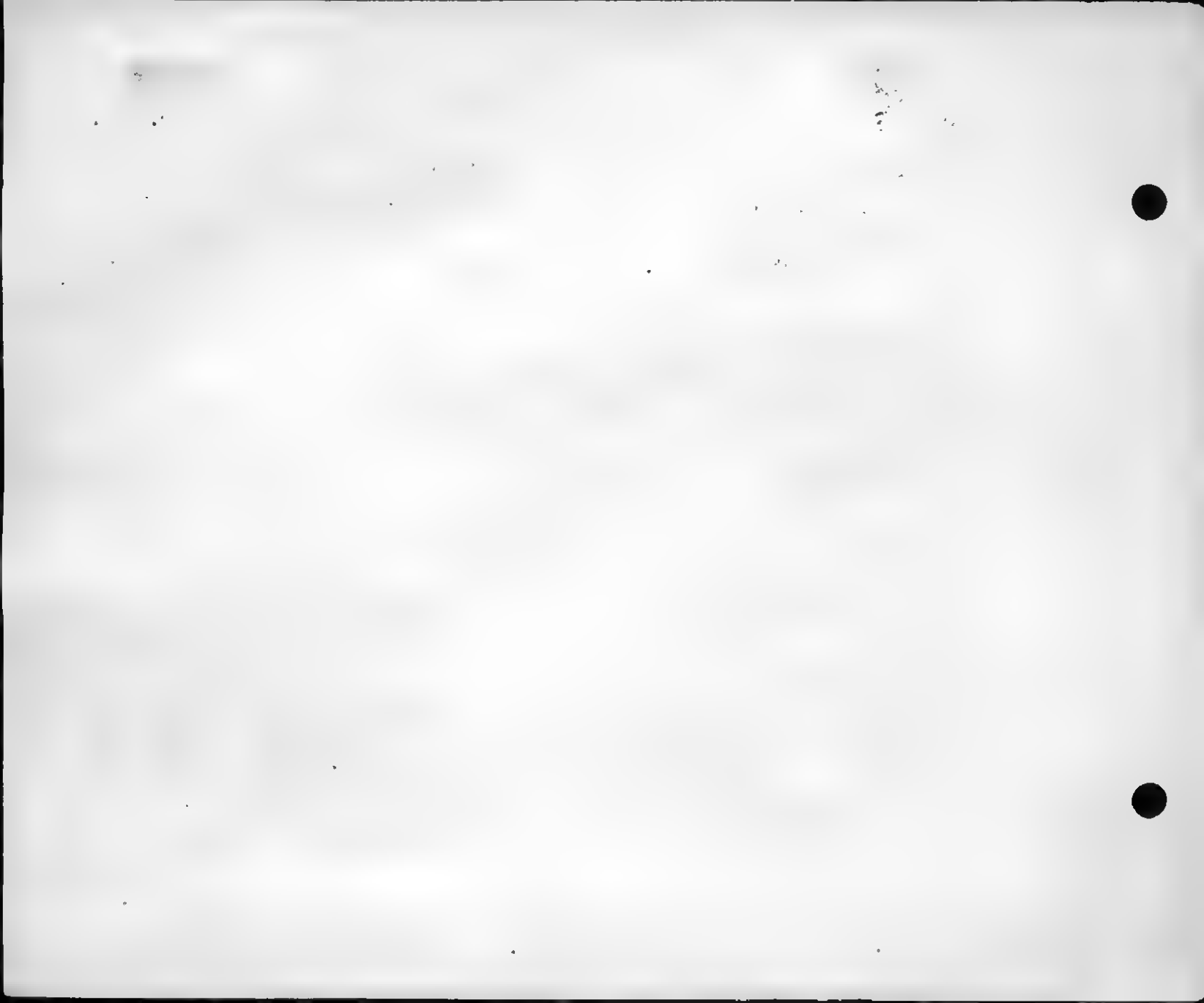
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04057

04056

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5419 Quintana Street		d. STREET ADDRESS 5419 Quintana Street	
3. NAME OF DECEASED (Type or print) First Middle Last Arthur F. Granholm		4. DATE OF DEATH Month Day Year March 17, 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 12, 1891
9. AGE (In years last birthday) 75		10. IF UNDER 1 YEAR Months Days 5 1/2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CIT. ZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Charles F Granholm		14. MOTHER'S MAIDEN NAME Josephine -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 718 14 9966	
17. INFORMANT Edna N Granholm		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 5 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 to 3-17, 1967 that (I) (we) last saw the deceased alive on 3-17, 1967 and that death occurred at 11 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Leonard Hays		22b. DATE SIGNED 3-18-67	
22c. PHYSICIAN'S NAME (Type) Leonard Hays		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland 1 ro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		25a. REC'D BY REGISTRAR 20 MAR 20 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04058

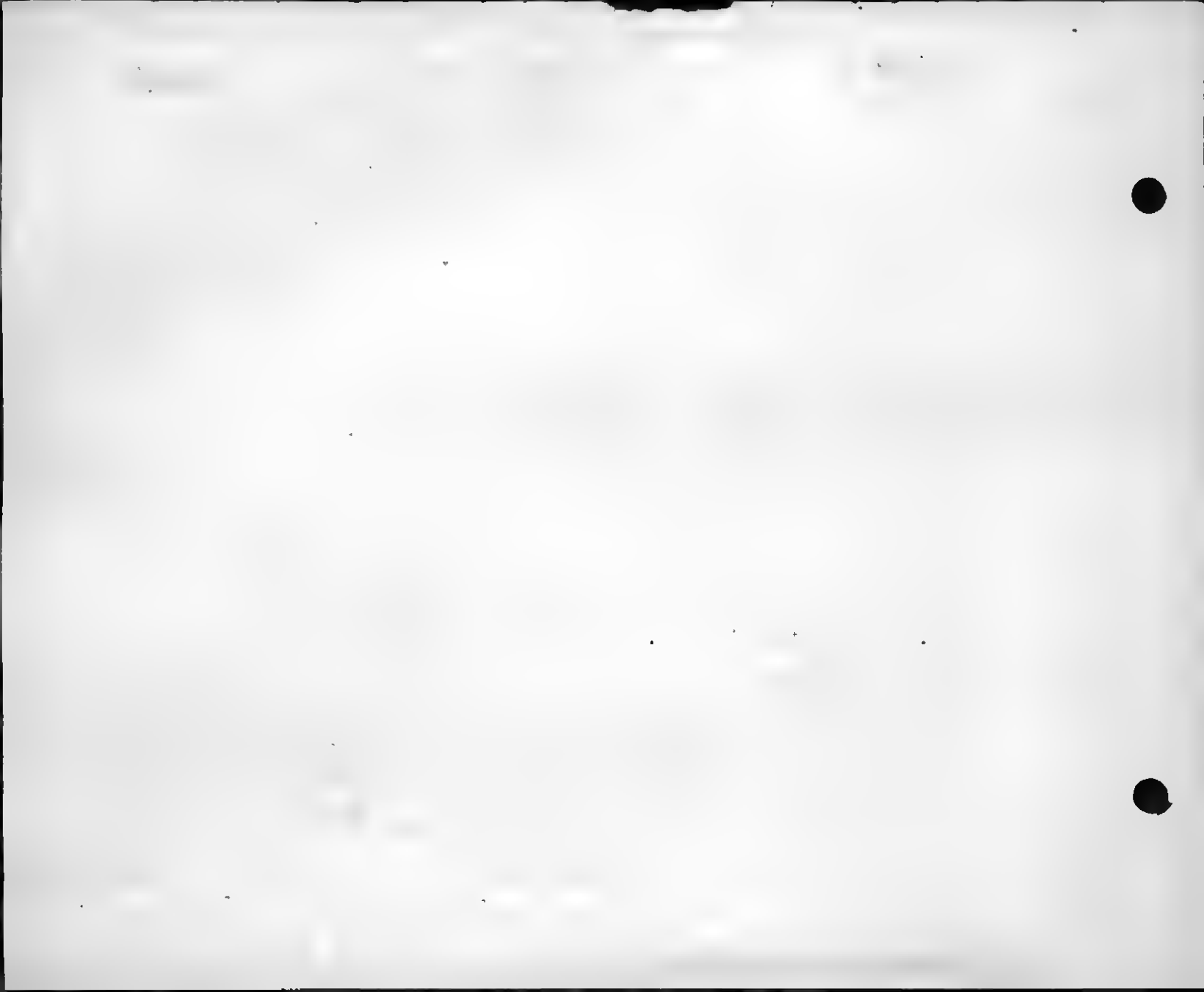
CERTIFICATE OF DEATH

04057

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AIRMAN'S AIR FORCE BASE</u>		c. LENGTH OF STAY IN 1b <u>15 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>USAF HOSPITAL ANDREWS</u>		d. STREET ADDRESS <u>225 ORANGE ST., S.E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BARBARA JUAN GRAY</u>		4. DATE OF DEATH Month Day Year <u>11 MARCH 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 DEC 1943</u>
9. AGE (in years lost birthday) <u>23</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN PINKNEY</u>	
14. MOTHER'S MAIDEN NAME <u>MINNIE FAIRWELL</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N/A</u>	
16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>JOHN P. GRAY</u> Address <u>HUSBAND SAME AS # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO <u>RENAL FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RENAL FAILURE</u> (c) <u>RENAL FAILURE</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Thrombocytopenia 2. Subarachnoid hemorrhage</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>24 FEB</u> , 19 <u>67</u> , to <u>11 MARCH 1967</u> , that (I) (we) last saw the deceased alive on <u>11 MARCH 1967</u> , and that death occurred at <u>1232AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles O. Judge</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-17-67</u>	23c. NAME OF CEMETERY OR CREMATOR <u>Orlinton National Orlinton</u>	23d. LOCATION (City or Town) (County) (State) <u>Va.</u>
24. FUNERAL DIRECTOR <u>Latney's funeral home, 3831 9a Avenue North</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>MAR 15 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

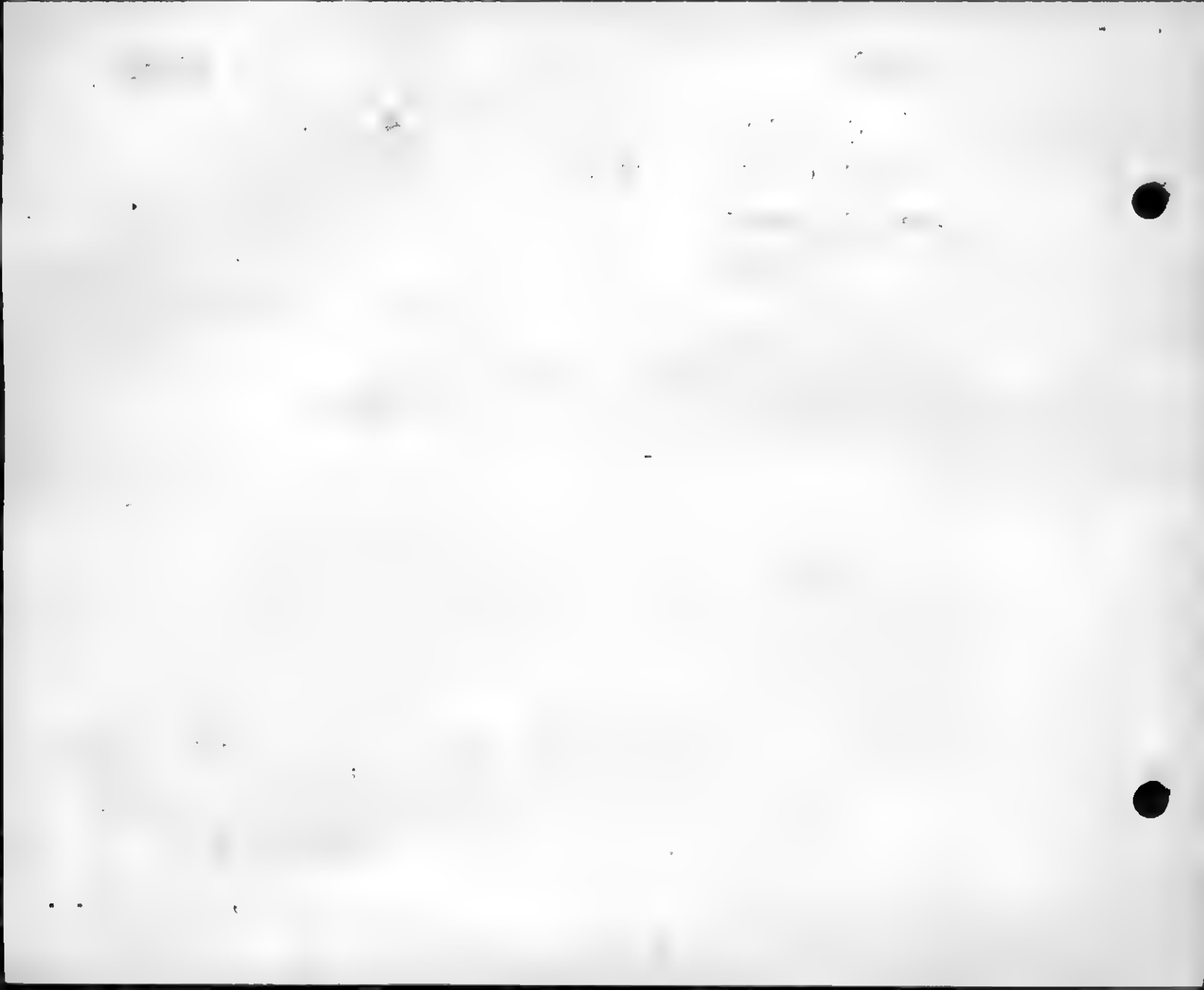
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04059

CERTIFICATE OF DEATH

04058

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE N. J. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN IS 24 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Montclair	
3 NAME OF DECEASED (Type or print) First Willie Middle Mae Last Gray		4 DATE OF DEATH Month 3 Day 11 Year 19 67	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/1909
9. AGE (In years last birthday) 57 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed	
11. BIRTHPLACE (County & State, or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Matthew Ackinson		14. MOTHER'S MAIDEN NAME Cora Bowlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-30-9738	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident, probably hemorrhage 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized arteriosclerosis (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease; diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from 2/15/ , 19 67 , to 3/11/ , 19 67 , that (he) (we) lost saw the deceased alive on 3/11/ , 19 67 , and that death occurred at 1:55AM , from causes on and on the date stated above.			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED 3/11/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/15/67	23c. NAME OF CEMETERY OR CREMATORY Heaven Rest	23d. LOCATION (City or Town) (County) (State) Manover N.J.
24. FUNERAL DIRECTOR <i>For: BROOKS & Allen, 12 St + 7th Ave. N.Y.</i>		25. REG'D BY REGIS. 3-13-67	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

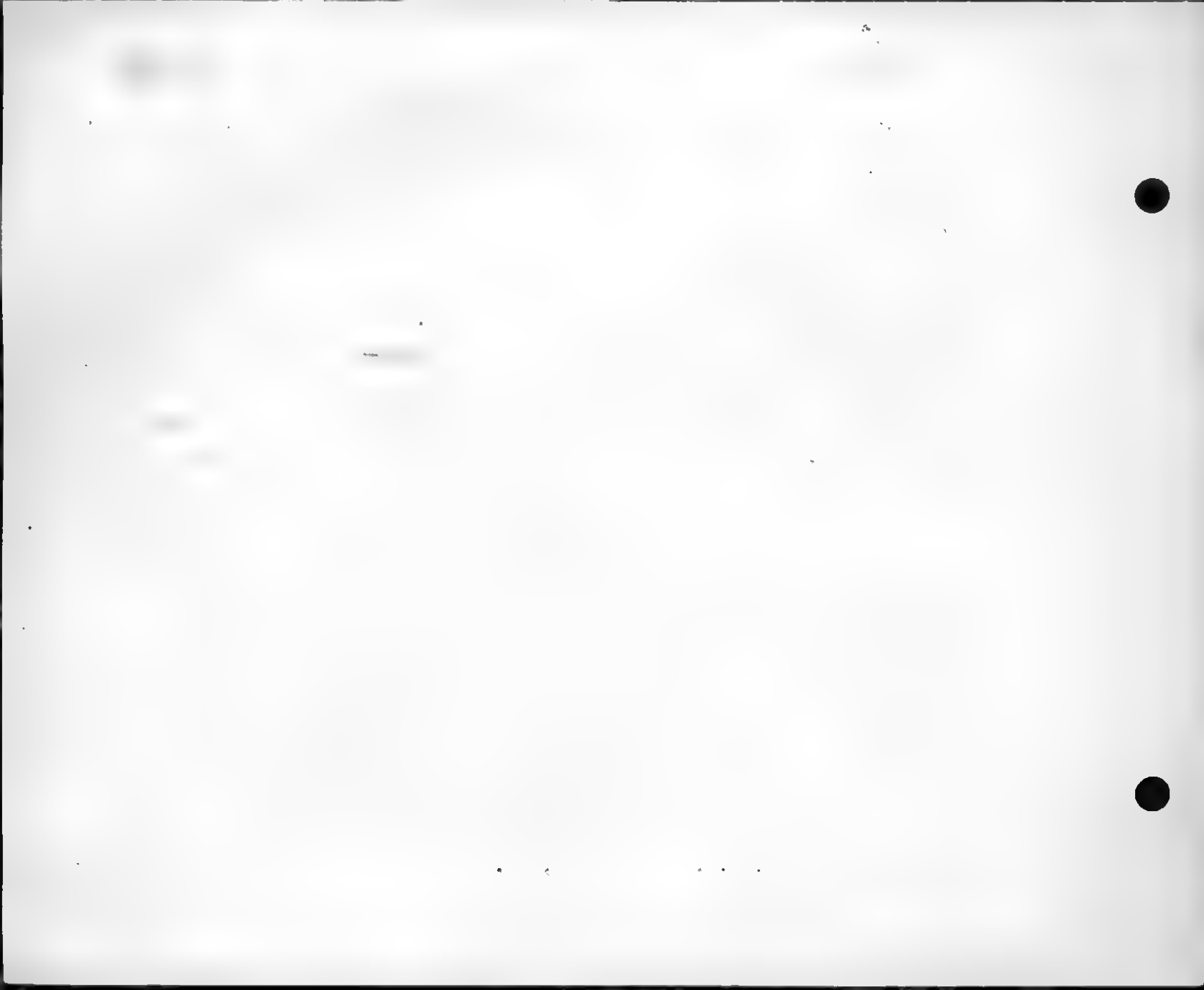
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04060

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04059

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4203 Braxton Place		d. STREET ADDRESS 4203 Braxton Place	
3. NAME OF DECEASED (Type or print) First Middle Last William Green		4. DATE OF DEATH Month Day Year 3 29 19 67	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Feb. 1884
9. AGE (In years lost birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Florist	
11. BIRTHPLACE (State or foreign country) the Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Green		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Betha Matthews		Address 8620 Johnson Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Epidermoid carcinoma of palate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH over 1 yr.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-30-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4-3-67	23c. NAME OF CEMETERY OR CREMATORY Nat. Harmony	23d. LOCATION (City or Town) (County) (State) Highland Park Md
24. FUNERAL DIRECTOR W. S. Washington & Sons 4925 Deane Ave NE		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

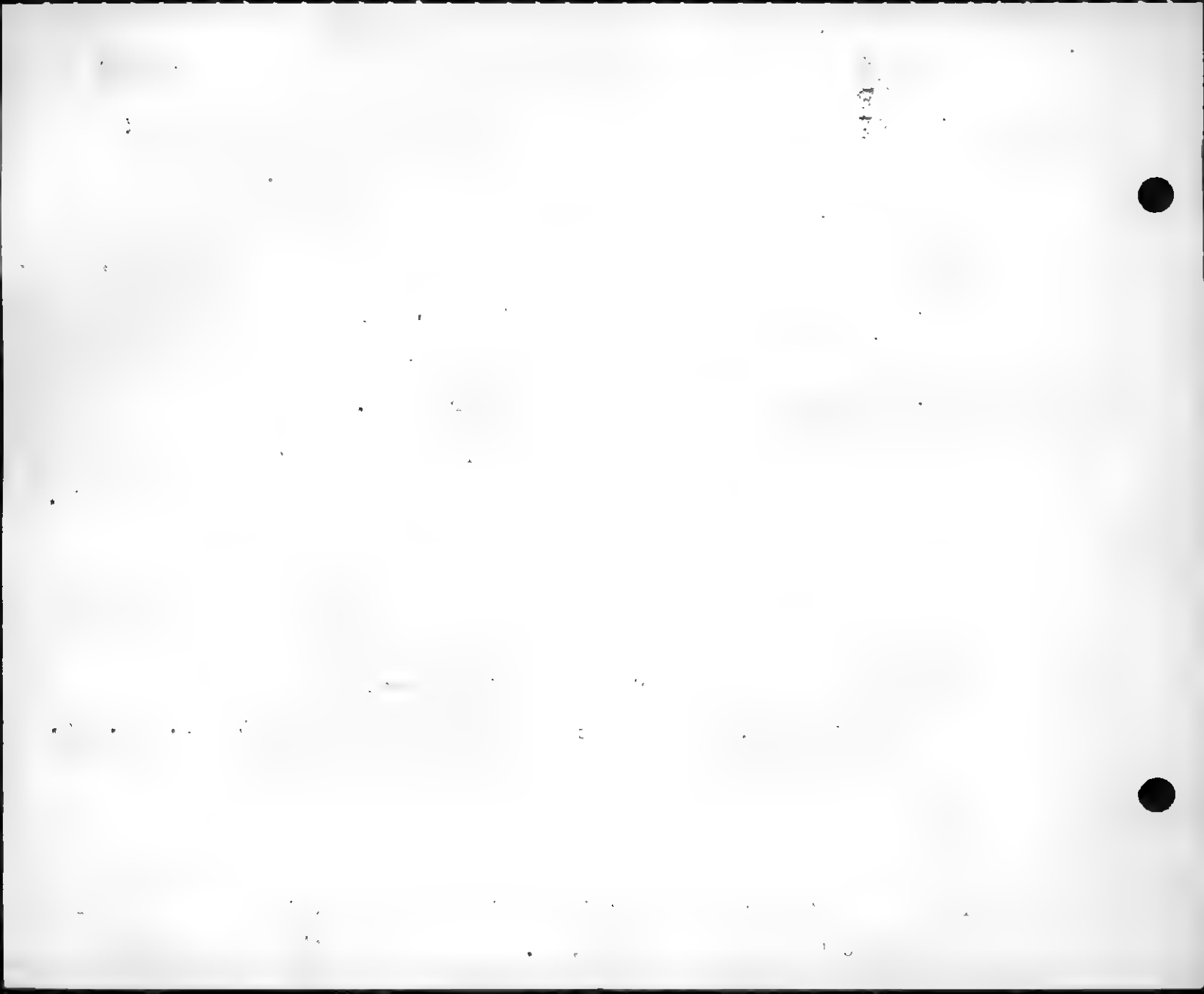
04061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04060

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c. LENGTH OF STAY IN 1b D O A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 9210 Springhill Lane	
3 NAME OF DECEASED (Type or print) Tori Allen Grossman		4 DATE OF DEATH Month March Day 18 , Year 67 .	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 26 April. 1963
9 AGE (in years last birthday) 3 yrs		10 IF UNDER 1 YEAR Months 16 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Grossman		14. MOTHER'S MAIDEN NAME Carolyn R. Wieser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO no	
17. INFORMANT Father		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 9294 IMMEDIATE CAUSE (a) DEVELOPING DROWNING DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH Few Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject fell in swimming pool	
20c. TIME OF INJURY Month, Day, Year 5:00 Hour a.m. 3/18 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> or work Not While <input checked="" type="checkbox"/> at work Swimming Pool	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Greenbelt		20f. (City or town) (County) (State) Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton O Watkins M.D.		22. DATE SIGNED 3/19/67	
EXAMINER'S NAME (Type) Dayton O Watkins		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 23 Mar 67	23c. NAME OF CEMETERY OR REPOSITORY Flushing Cemetery	23d. LOCATION (City or Town) (County) (State) Flushing New York
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

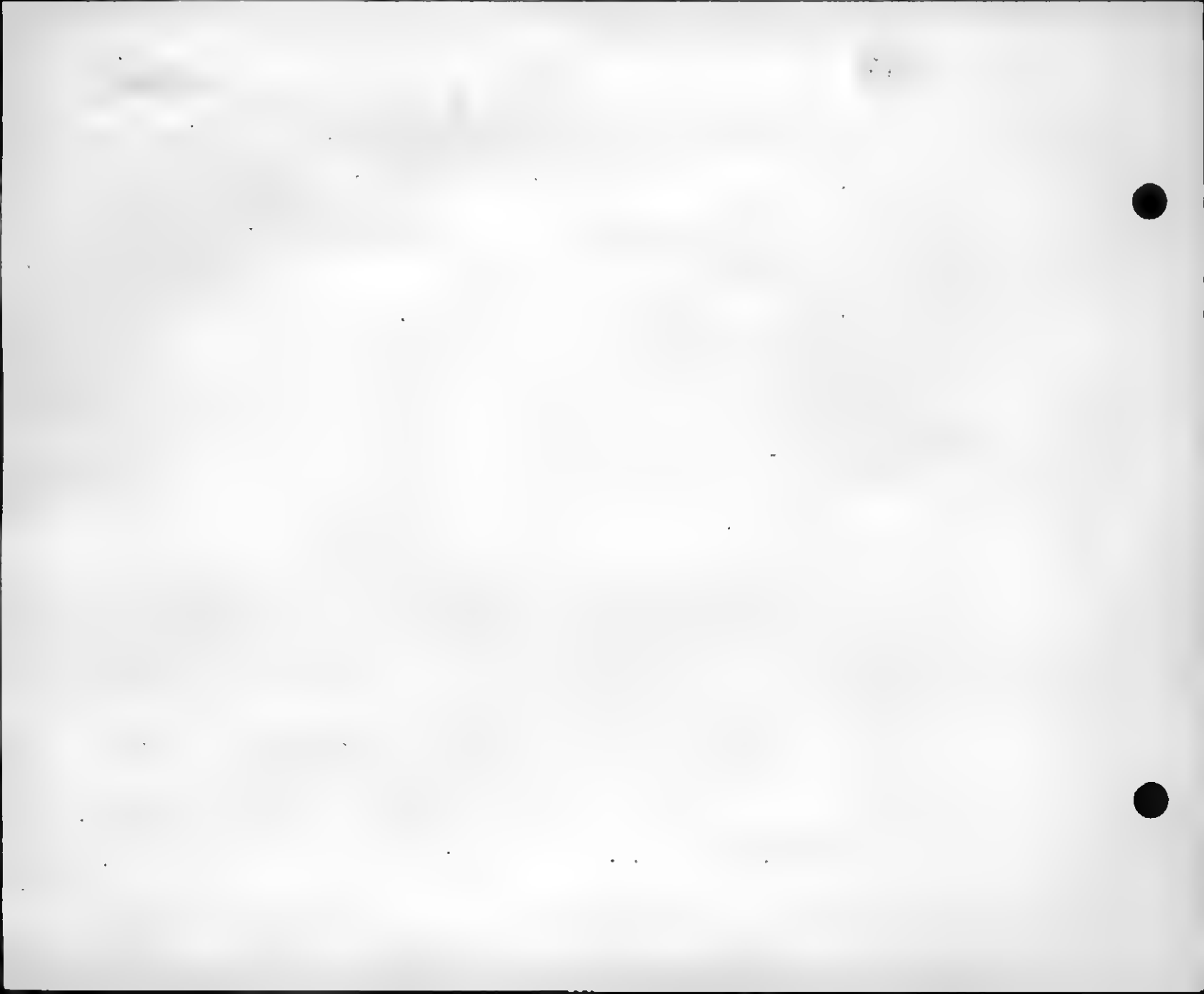
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04062

04061

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 2506 Clark Ave.	
3 NAME OF DECEASED (Type or print) First Naomi Middle F Last Haga		4 DATE OF DEATH Month March Day 14 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Aug., 1907
9 AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 14 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11 BIRTHPLACE (County & State, or foreign country) Pott Creek, Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Wm. Oyler		14. MOTHER'S MAIDEN NAME Fannie Catherine Tucker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Ray Haga, Laurel, Md	
17. INFORMANT Ray Haga, Laurel, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) congestive heart failure DOE-TO (b) RT coronary thrombosis DOE-TO (c) Blat pulmonary edema -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 3, 1967 to March 14, 1967 , that (I) (we) last saw the deceased alive on March 14, 1967 , and that death occurred at 6:20 PM , from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED March 15, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince Georges General Hospital, Cheverly	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried	23b. DATE THEREOF 3-17-67	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City or Town) (County) (State) Burtonville, Md.
24. FUNERAL DIRECTOR De Witt D. Anderson		25a. REC'D BY REGISTRAR APR 20 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE HEALTH DEPT.

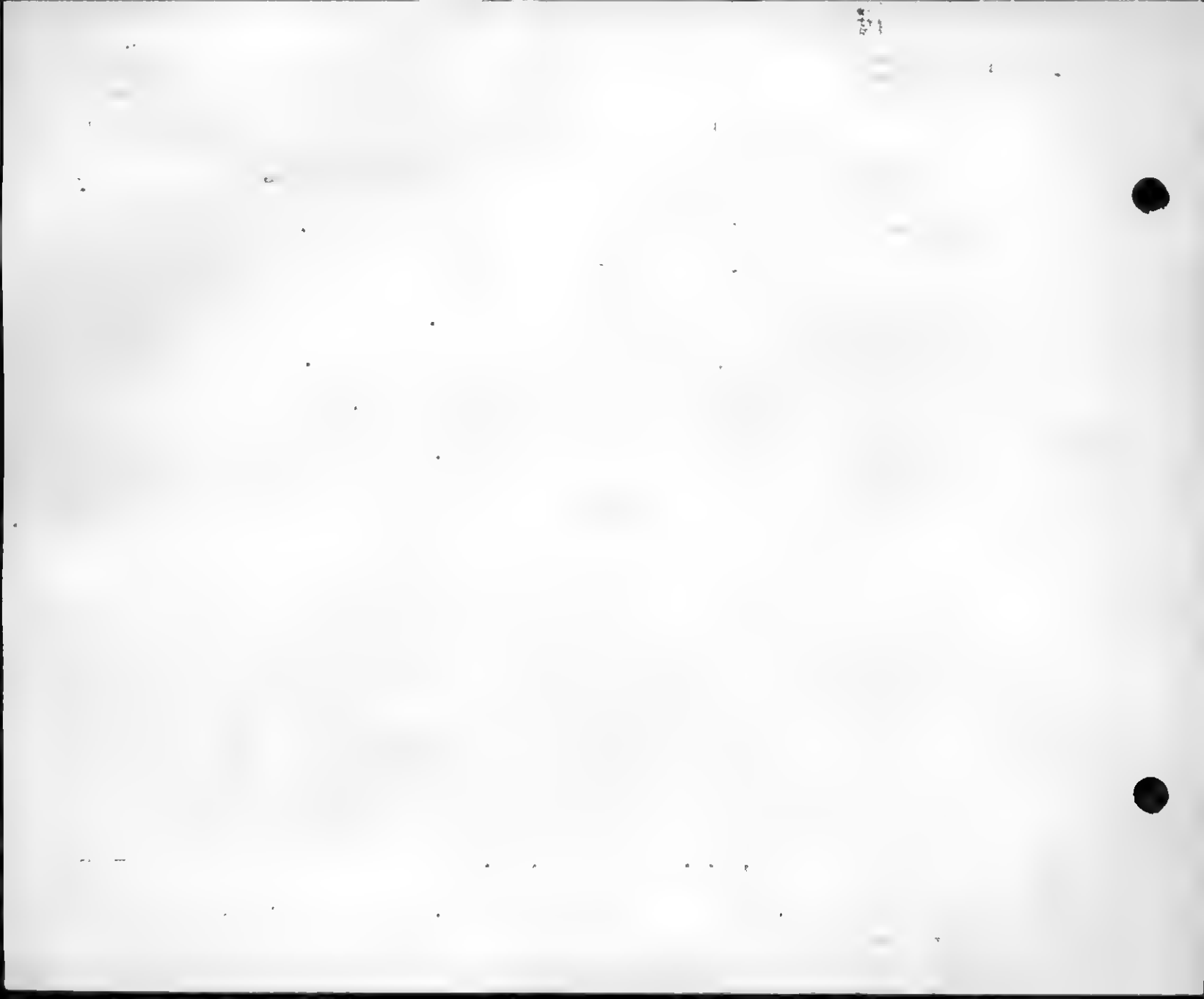
04063

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04062

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill pages 1 and 2 within the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY In b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e STREET ADDRESS 2803 Keating St.	
3 NAME OF DECEASED (Type or print) First Edward Middle Mack Last Hall		4 DATE OF DEATH Month 3 Day 30 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6 Nov. 1907
9 AGE (In years last birthday) 59 yrs		10 UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Navy Dept.		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Greenville, S. Carolina		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Edward H. Hall		14 MOTHER'S MAIDEN NAME Effie E. Butler	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Mary F. Hall (Wife)		Address Same as Item #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town, (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-31-67	
23a B. RIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Apr. 3-67	
23c NAME OF CEMETERY OR CREMATORY Washington Nat'l.		23d LOCATION (City or town) (County) (State) Suitland, Maryland	
24 FUNERAL DIRECTOR Silmons Bros.		25a REC'D BY REGISTRAR APR 3 1967	
ADDRESS 1661 Good Hope Rd SE Wash DC		25b REGISTRAR'S SIGNATURE Charles J. [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #11 & 12 Film #3186 3/16/67 pc

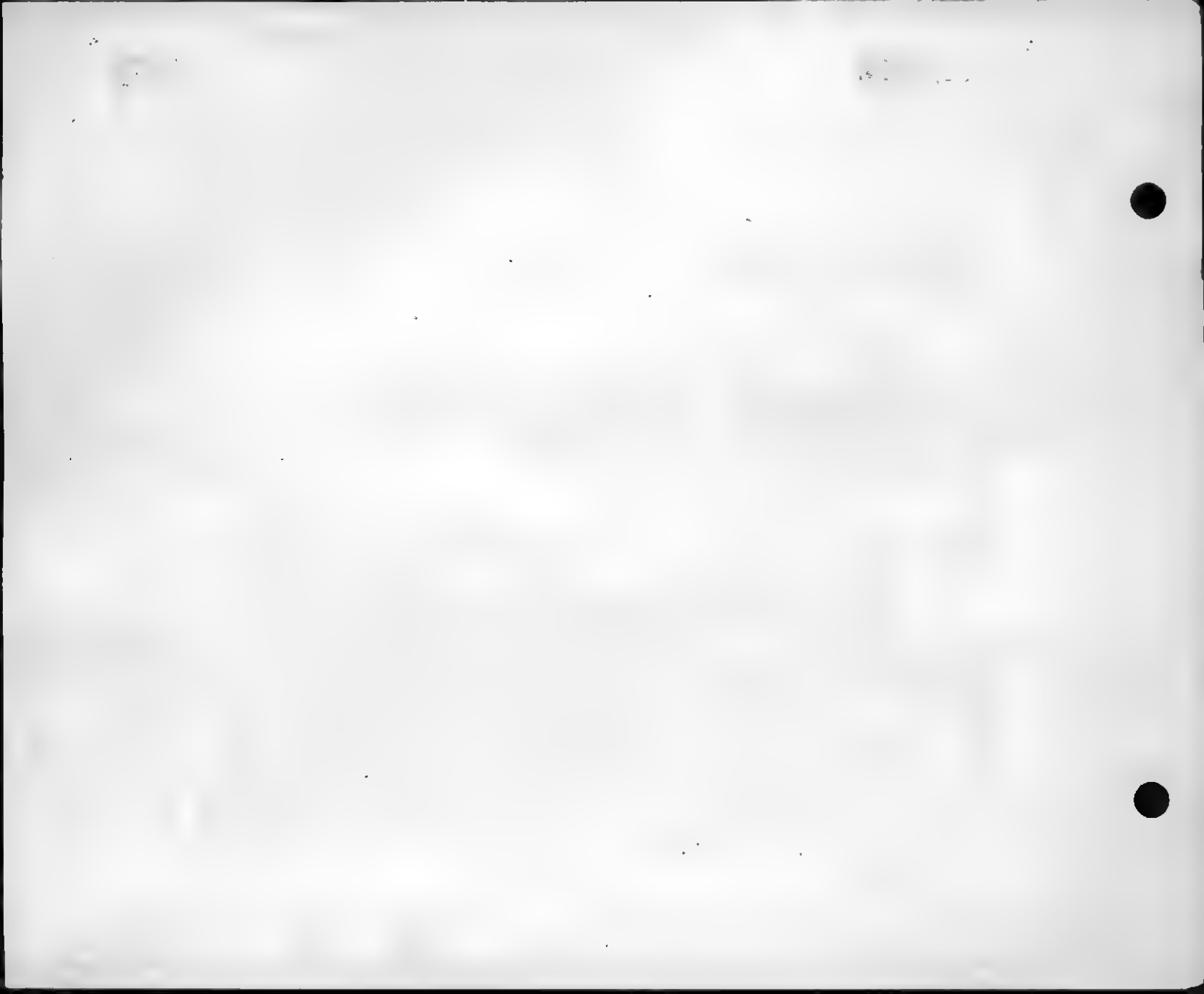
04064

CERTIFICATE OF DEATH

04063

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 11266 Evans Trail	
3. NAME OF DECEASED (Type or print) First Edwin Middle Hamilton Last Hamilton		4. DATE OF DEATH Month March Day 7 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Aug., 1899
9. AGE (in years last birthday) yrs. 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman	
11. BIRTHPLACE (County & State or foreign country) Remington, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh Hamilton		14. MOTHER'S MAIDEN NAME Mary Clementine Slaughter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW 11		16. SOCIAL SECURITY NO 119-07-2185	
17. INFORMANT Mrs. Elsie V. Hamilton, Beltsville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Necrosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-15, 1967 to 3-7, 1967 , that (I) (we) last saw the deceased alive on 3-6, 1967 , and that death occurred 8:50AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. A. Deitz		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) Dr. A. Deitz, M.D.		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 8, 1967	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City or Town) (County) (State) Richmond, Virginia	
24. FUNERAL DIRECTOR Ives Funeral Home		25a. REC'D BY REGISTRAR MAR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Arlington, Virginia	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05630

05630

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS Box 2375 Leland Rd., South	
3 NAME OF DECEASED (Type or print) Benjamin Hardesty		4 DATE OF DEATH Month 3 Day 25 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11 May 1893
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b KIND OF BUSINESS OR INDUSTRY Tenant	9 AGE (In years last birthday) 73 yrs
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Benjamin Hardesty		14. MOTHER'S MAIDEN NAME Elizabeth Chaney	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 219-36-7712	
17 INFORMANT Mrs. Mary Hardesty-#2.		Address Same as Item #2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes over 2 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-26-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, or other disposition (Type) Burial	23b DATE THEREOF 3/30/67	23c NAME OF CEMETERY OR CREMATORY Alexandria Nat'l Cem.	23d LOCATION (City or Town) (County) (State) Alexandria, Va.
24 FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a REC'D BY REGISTRAR DATE APR 12 1967	25b REGISTRAR'S SIGNATURE f Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

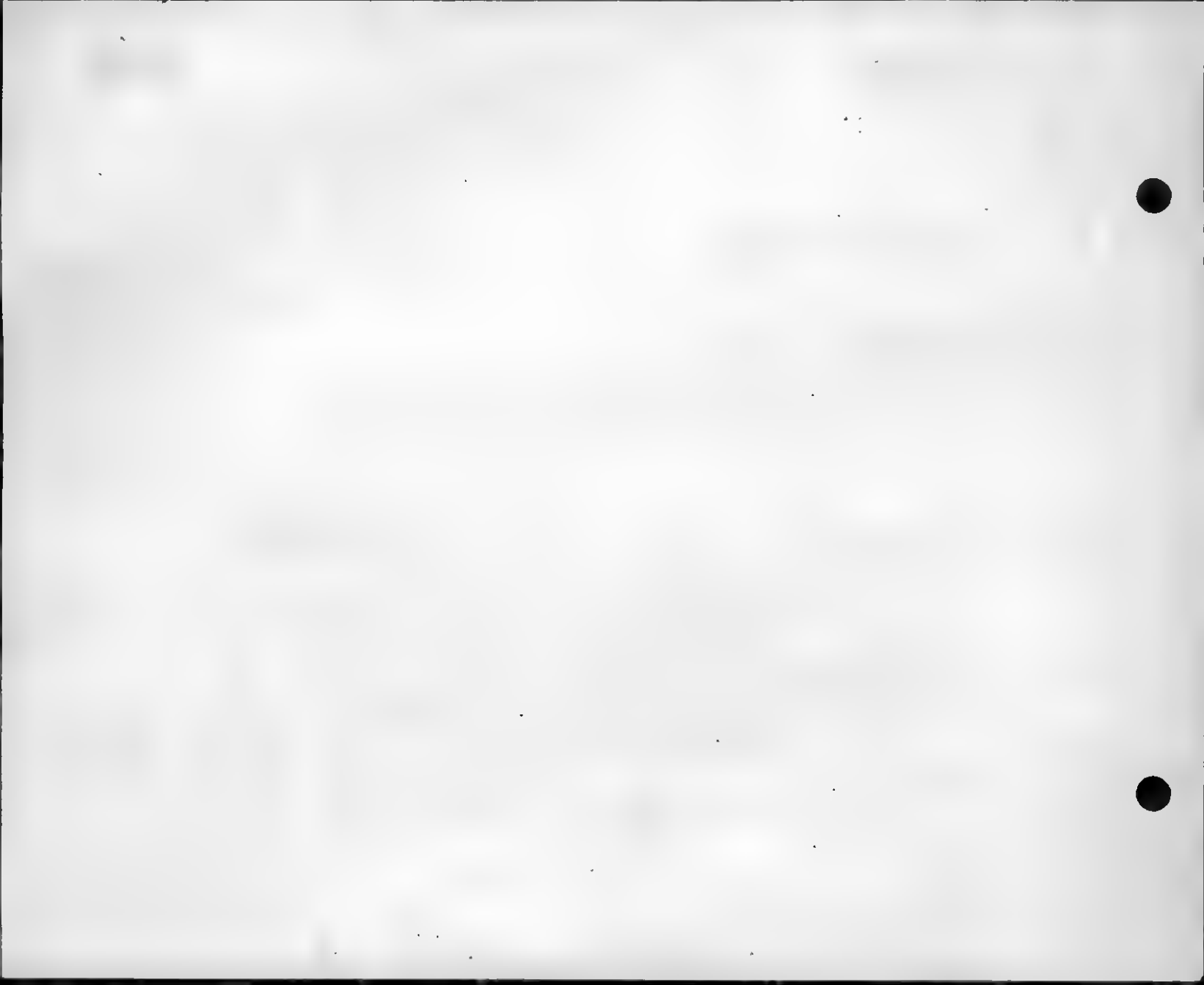
04065

Item 9 Film 3356 3/17/67 HC

CERTIFICATE OF DEATH

04064

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>DE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenleaf</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Center</u>				d. STREET ADDRESS <u>Washington 473</u>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>R. T.</u> Last <u>Hardisty</u>				4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/1876</u>	9. AGE (In years last birthday) <u>90 1/2</u> yrs.	IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>12</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A. Tebeault</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. White</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT <u>Gwendolyn Chilton Boston, Mass.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion</u> DUE TO <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Stenosis</u> (b) <u>Stenosis</u> (c) <u>Stenosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis - 0.5 - 1.0 - 1.5 - 2.0 - 2.5 - 3.0 - 3.5 - 4.0 - 4.5 - 5.0 - 5.5 - 6.0 - 6.5 - 7.0 - 7.5 - 8.0 - 8.5 - 9.0 - 9.5 - 10.0 - 10.5 - 11.0 - 11.5 - 12.0 - 12.5 - 13.0 - 13.5 - 14.0 - 14.5 - 15.0 - 15.5 - 16.0 - 16.5 - 17.0 - 17.5 - 18.0 - 18.5 - 19.0 - 19.5 - 20.0 - 20.5 - 21.0 - 21.5 - 22.0 - 22.5 - 23.0 - 23.5 - 24.0 - 24.5 - 25.0 - 25.5 - 26.0 - 26.5 - 27.0 - 27.5 - 28.0 - 28.5 - 29.0 - 29.5 - 30.0 - 30.5 - 31.0 - 31.5 - 32.0 - 32.5 - 33.0 - 33.5 - 34.0 - 34.5 - 35.0 - 35.5 - 36.0 - 36.5 - 37.0 - 37.5 - 38.0 - 38.5 - 39.0 - 39.5 - 40.0 - 40.5 - 41.0 - 41.5 - 42.0 - 42.5 - 43.0 - 43.5 - 44.0 - 44.5 - 45.0 - 45.5 - 46.0 - 46.5 - 47.0 - 47.5 - 48.0 - 48.5 - 49.0 - 49.5 - 50.0 - 50.5 - 51.0 - 51.5 - 52.0 - 52.5 - 53.0 - 53.5 - 54.0 - 54.5 - 55.0 - 55.5 - 56.0 - 56.5 - 57.0 - 57.5 - 58.0 - 58.5 - 59.0 - 59.5 - 60.0 - 60.5 - 61.0 - 61.5 - 62.0 - 62.5 - 63.0 - 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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

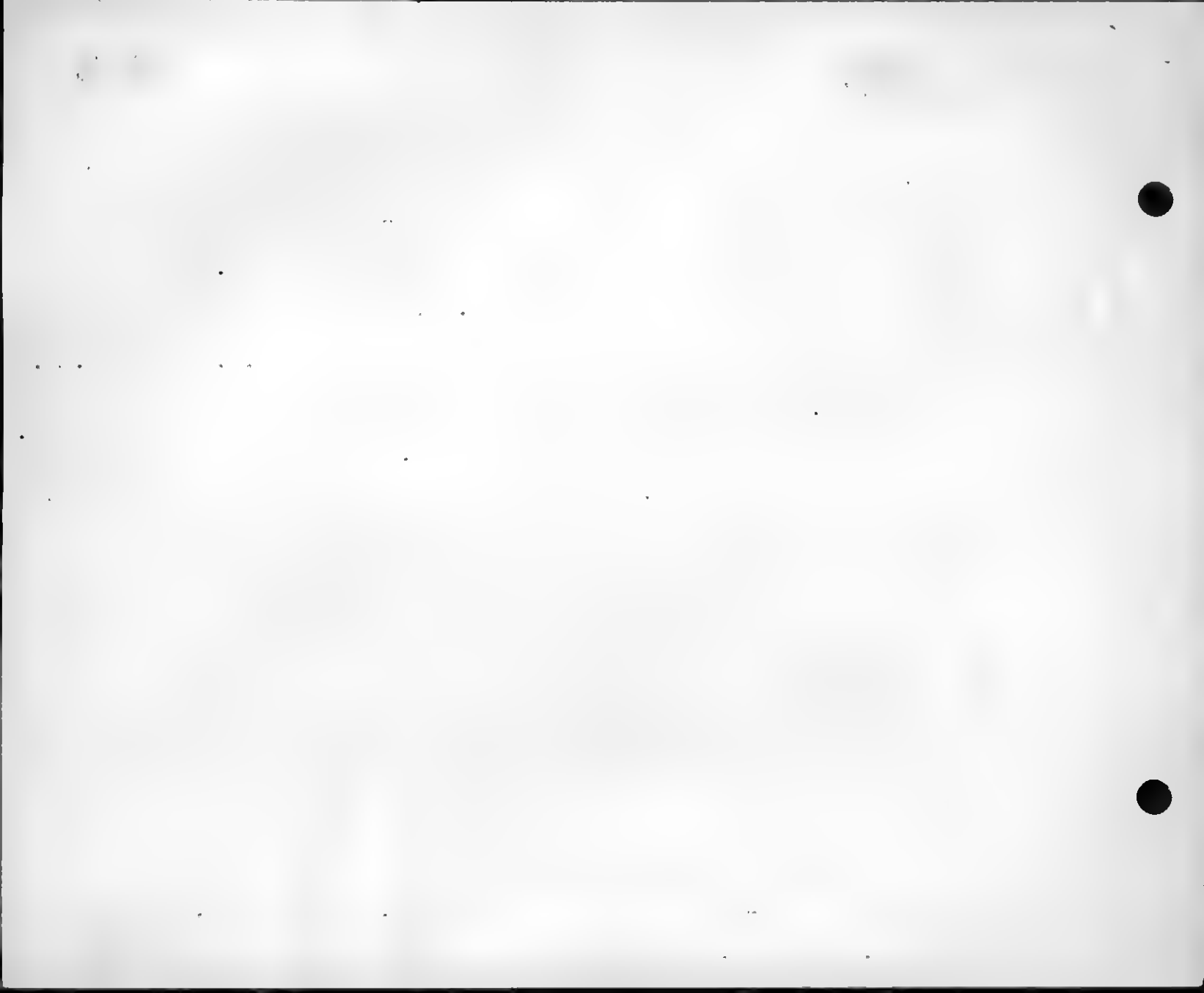
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04066

CERTIFICATE OF DEATH

04065

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6705 - 22nd Place		d. STREET ADDRESS 6705 - 22nd Place	
3 NAME OF DECEASED (Type or print) LORETTA J HARRINGTON		4. DATE OF DEATH Month Mar. Day 2, Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 3, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11 BIRTHPLACE (County & State, or foreign country) U. S.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Richard J. Harrington		14. MOTHER'S MAIDEN NAME Katharina Englert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 7531 DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) CONGENITAL BRAIN DAMAGE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 10-3-61	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED CONVULSION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-3 , 19 61 , to 3-2 , 19 67 , that (I) (we) last saw the deceased alive on FEB 17 , 19 67 , and that death occurred at 1:30 A.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>Donald J. [Signature]</i>		22b. DATE SIGNED 3/2/67	
22c. PHYSICIAN'S NAME (Type) HOROLD F. [Signature]		22d. ADDRESS 352 UNIVERSITY RD S	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-6-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 10 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



* THE MEDICAL EXAMINER FOR PRINCE GEORGE'S COUNTY WAS NOTIFIED AND RELEASED THE REMAINS TO US. HOSP ANDREWS TO HOSPITAL OR ATTENDING PHYSICIAN AND PREPARATION OF DEATH CERTIFICATE.

Page 4 may be retained by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

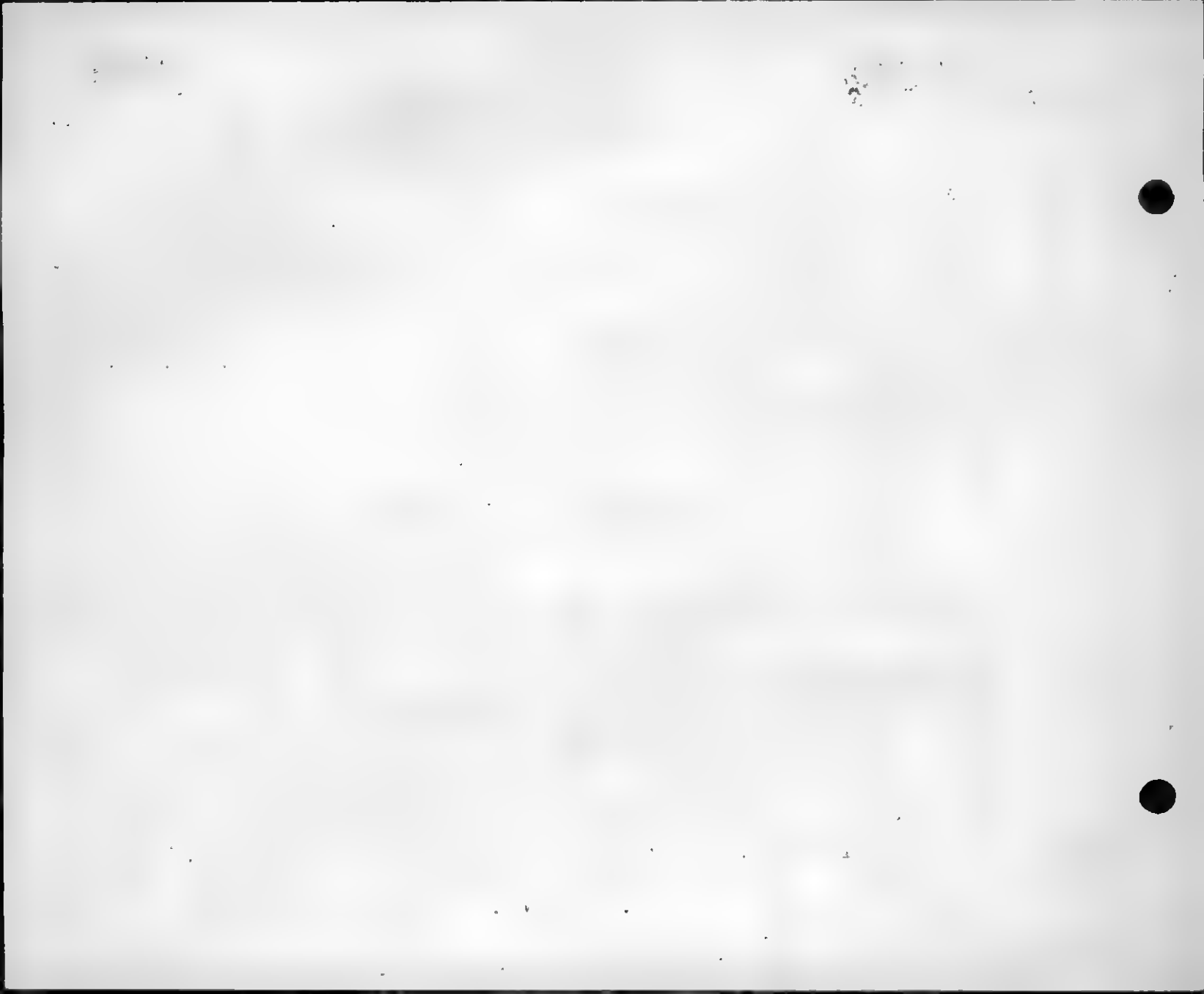
04067

CERTIFICATE OF DEATH

04066

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB c. LENGTH OF STAY IN 1b DOA * d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND d. STREET ADDRESS 3001 PEARL DR, APT 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) DALE CLAYTON HARRIS			4. DATE OF DEATH Month MARCH Day 20 Year 19 67		
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 DEC 66		9. AGE (In years last birthday) Yrs. 3 Months 9 Days 9 Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME GARY LEROY HARRIS		
14. MOTHER'S MAIDEN NAME PATRICIA LUCILLE PATTERSON			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		
16. SOCIAL SECURITY NO. NONE			17. INFORMANT FATHER Address SAME AS #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PNEUMONITIS, BILATERAL, VIRAL ETIOLOGY, DUE TO (SDII) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (u) (this hospital) attended the deceased from 11 Dec , 19 66 , to 20 March 19 67 that (u) (we) last saw the deceased alive on 25 Jan 19 67 , and that death occurred at 1:40 PM , from causes and on the date stated above.					
22a. SIGNATURE <i>Sidney Goldman</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 20 MARCH 67	
22c. PHYSICIAN'S NAME (Type) SIDNEY GOLDMAN, CAPT USAF MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB WASH DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/25/67	23c. NAME OF CEMETERY OR CREMATORY FT. LOGAN NAT. CEMETERY		23d. LOCATION (City or Town) (County) (State) DENVER, COLORADO	
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND			25a. REC'D BY REGISTRAR DATE 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MICROFILM CERTIFICATION



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04068

04067

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital					d. STREET ADDRESS 5220 56th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Ralph Sheckles Harvey				4 DATE OF DEATH Month Day Year March 10 1967			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-15-03		9 AGE (In years last birthday) 63 yrs	10 IF UNDER 24 HRS Months Days Hours Min	11 IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired owner			10b. KIND OF BUSINESS OR INDUSTRY Poultry farm		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Franklin Pierce Harvey				14. MOTHER'S MAIDEN NAME Lulie King			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214 03 8226		17. INFORMANT Pauline F. Harvey		Address Riverdale, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) over 3 yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				22. DATE SIGNED 3-11-67			
EXAMINER'S NAME (Type) John Kehoe, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address Riverdale, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Whitfield Cemetery		23d. LOCATION (City or Town) (County) (State) Lanham Pro Georges Md.	
24 FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		MAR 14 1967 DATE	

REGISTERED BY REGISTRAR
DATE
Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item 7 Film 4386 3/12/67 kk

04069

CERTIFICATE OF DEATH

04068

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

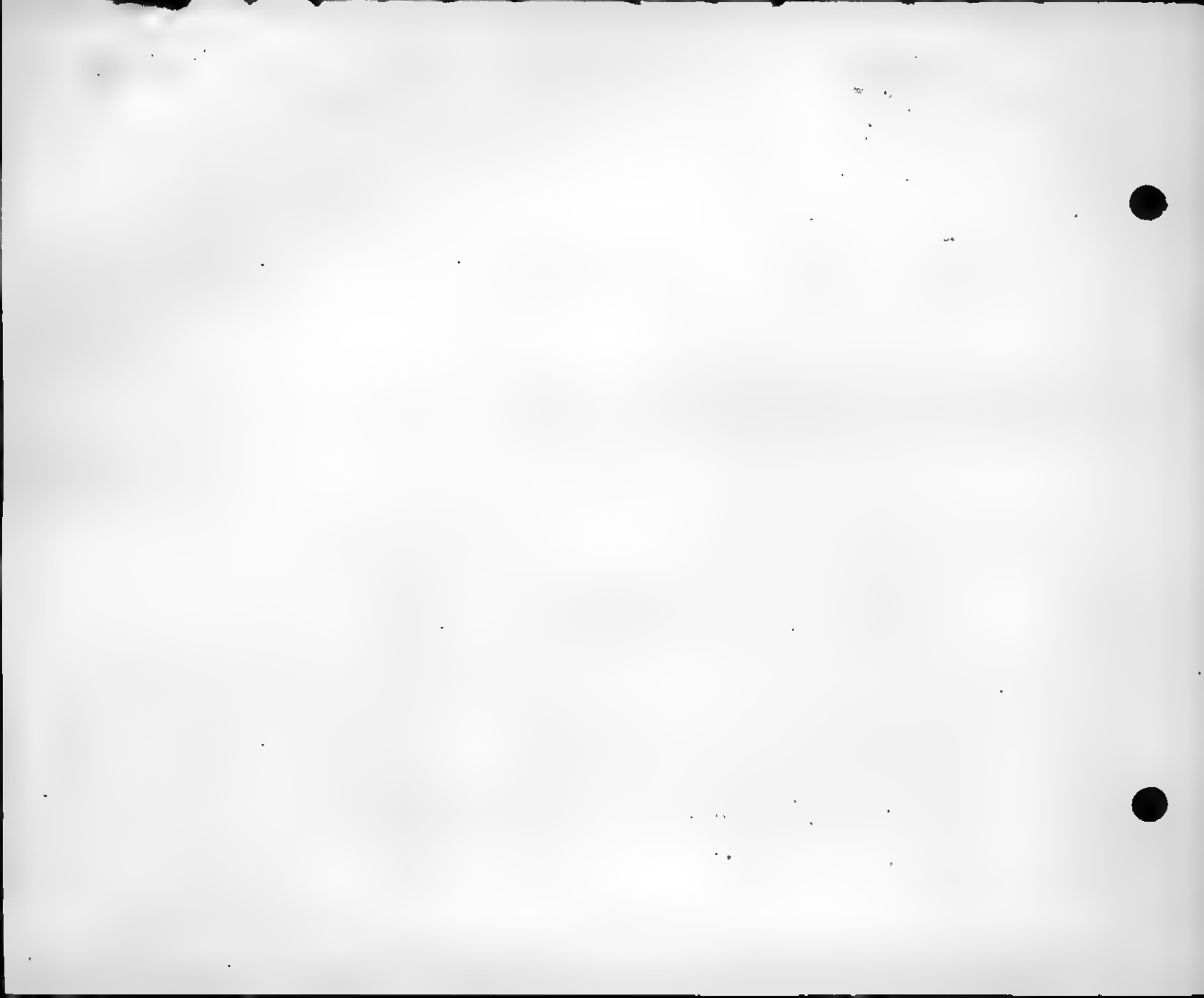
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. STREET ADDRESS 3701 Nicholson St.			
3. NAME OF DECEASED (Type or print) First Clerc Middle W. Last Hawk				4. DATE OF DEATH Month March Day 11 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/9/04	
9. AGE (In years, last birthday) yrs. 62		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired examiner		10b. KIND OF BUSINESS OR INDUSTRY S Government		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Amos Hawk			
14. MOTHER'S MAIDEN NAME Addie M Mc Calley				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. 577 42 1623				17. INFORMANT Edith Helen Hawk Address Hyattsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Cerebral Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. , 1967, to March 11 , 1967, that (I) (we) last saw the deceased alive on 3-11 , 1967, and that death occurred at 2:45 M, from causes and on the date stated above.							
22a. SIGNATURE Donald C. Edgren M.D.				22b. DATE SIGNED PM		22c. PHYSICIAN'S NAME (Type) DONALD C. EDGREN	
22d. ADDRESS Hyattsville, Md.				22e. REC'D BY REG. STRAR MAR 15 1967			
22f. REG. STRAR'S SIGNATURE Charles Judge				22g. REG. STRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 14, 1967		23c. NAME OF CEMETERY OR INTERMENT PLACE George Washington		23d. LOCATION (City or Town) (County) (State) Hyattsville 'ro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Address Hyattsville, Md.				25. REC'D BY REG. STRAR MAR 15 1967			
25a. REC'D BY REG. STRAR				25b. REC. STRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04070		Item #2 a,b,c,d film #0387322/01 DC						04069			
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Prince Georges</u>						a. STATE <u>M.D.C.</u> b. COUNTY <u>PRINCE GEORGES</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wash.</u>					
c. LENGTH OF STAY IN 1b <u>2 mos</u>						d. STREET ADDRESS <u>4025 Argyle Terrace</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hyattsville Nursing Home</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>George</u> Last <u>Heilbronn</u>						4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12, 1873</u>		9. AGE (in years last birthday) <u>93 yrs.</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Retired) - Stenographer</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Gardensville, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Herman Heilbronn</u>						14. MOTHER'S MAIDEN NAME <u>Christina</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, cecum</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 22, 1966</u> to <u>present</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>William F. Simpson</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>William F. Simpson, MD</u>						22d. ADDRESS <u>6216 N.H. Ave. NE</u>					
23a. BURIAL CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>13-7-67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Wash., D.C.</u>			
24. FUNERAL DIRECTOR <u>Anton Funeral Home</u>						25a. REC'D BY REGISTRAR <u>MAR 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

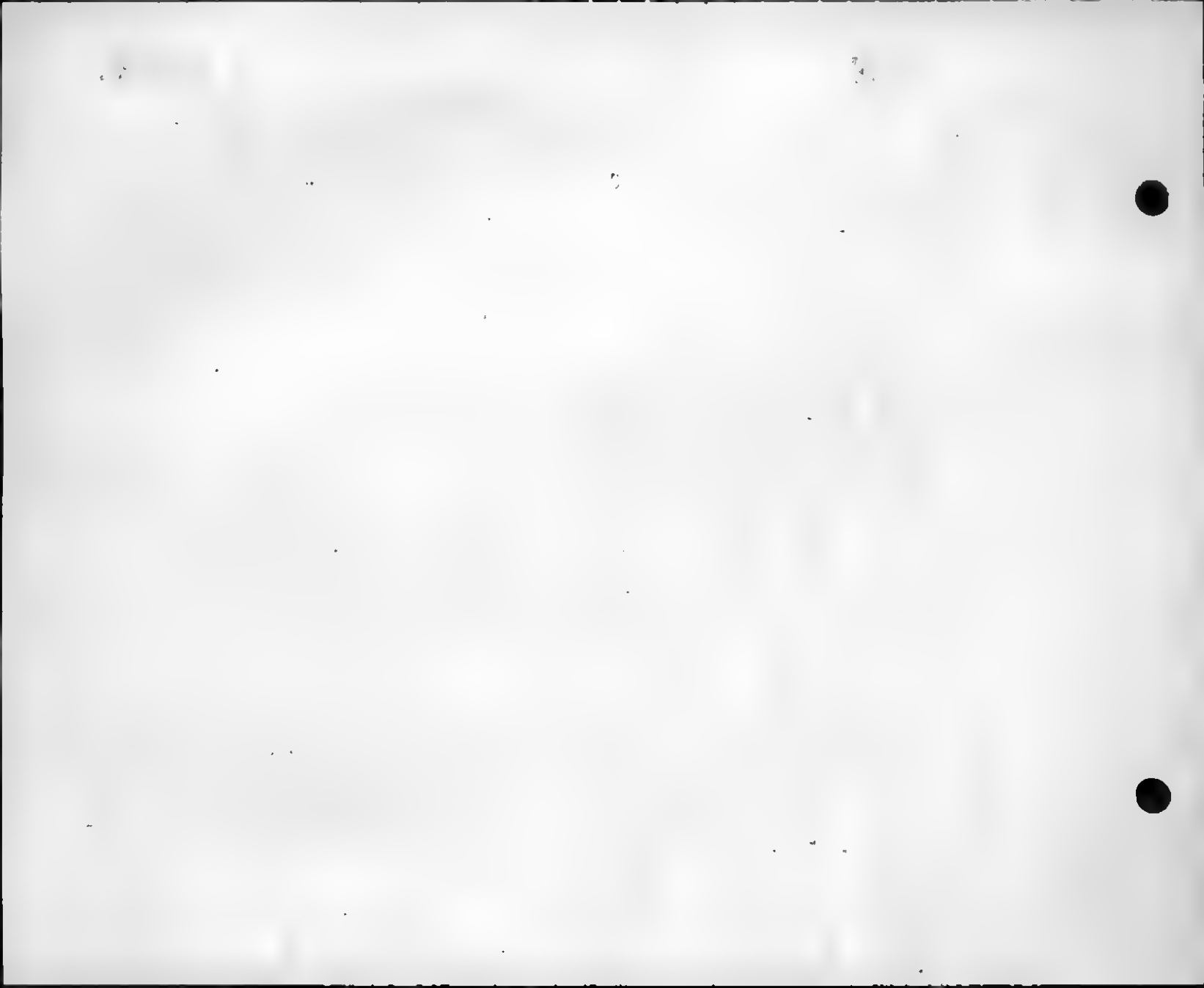
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04071

CERTIFICATE OF DEATH

04070

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE			c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORRESTVILLE 16.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 7483 KEYSTONE LANE, APT 203		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last KRIS (NMI) HEILBRUN				4. DATE OF DEATH Month Day Year MARCH 22 1967			
5. SEX FEMALE		6. CDR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 20 MARCH 1967	
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months Days Hours Min 3		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD HEILBRUN				14. MOTHER'S MAIDEN NAME JOAN CECILIA ALADICS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address FATHER SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) PROBABLE ELECTROLYTE IMBALANCE DUE TO (c) SEPSIS AND RENAL FAILURE						INTERVAL BETWEEN ONSET AND DEATH 30 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 19 March, 1967 to 22 March 1967 that (X) (we) last saw the deceased alive on 22 March 1967 and that death occurred at 1:00 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Herrick Jay Cohen</i>				22b. DATE SIGNED 22 March 67		22c. PHYSICIAN'S NAME (Type) HERRICK JAY COHEN	
22d. ADDRESS USAF HOSPITAL ANDREWS				22e. ADDRESS ANDREWS AFB, WASH DC 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-24-67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR BERNARD DANZANSKY AND SONS				25. REC'D BY REGISTRAR DC MAR 27 1967		25a. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



FOR STATE
HEALTH DEPT.

04072

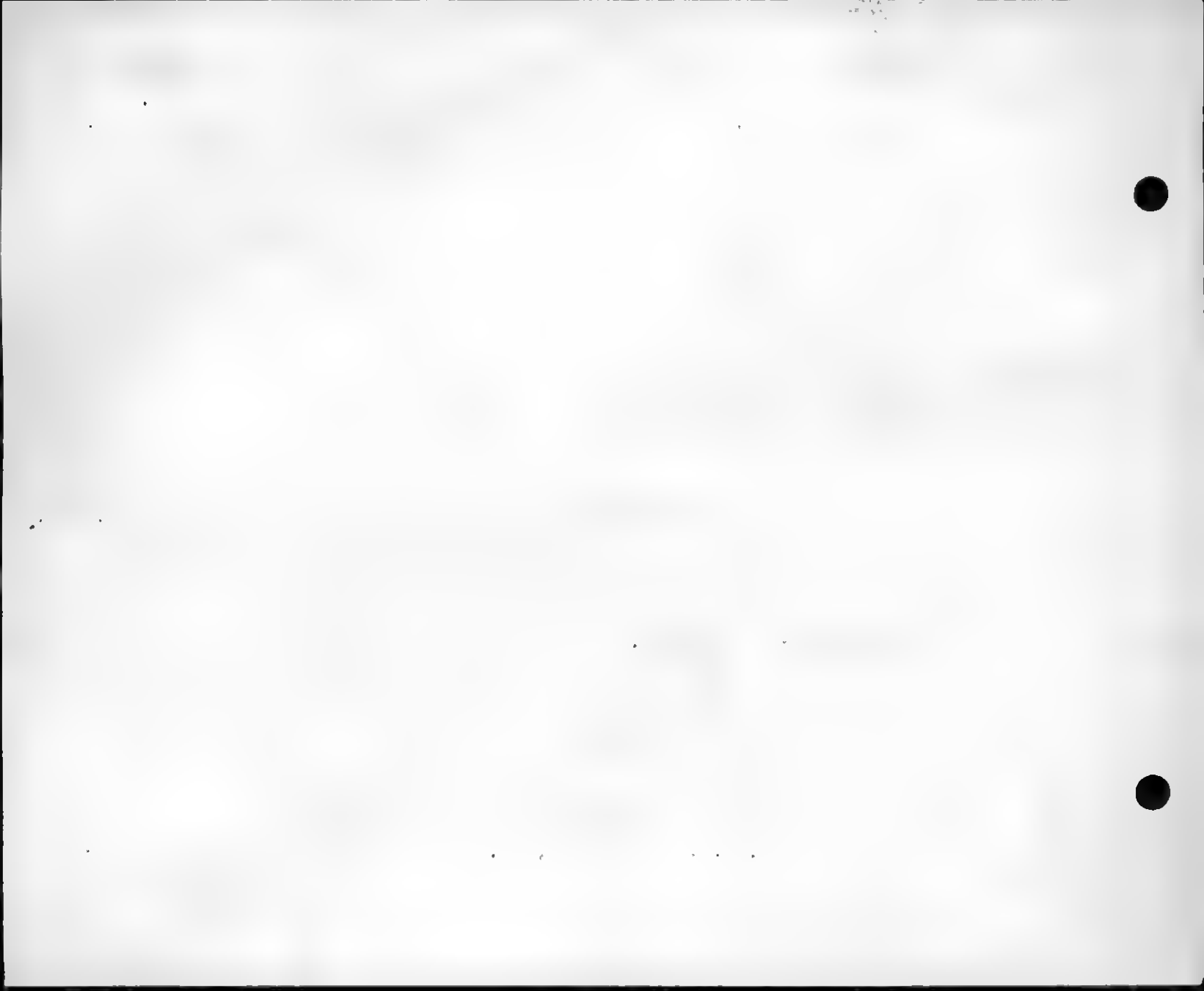
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04071

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY N 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 3713 Taylor Street	
3 NAME OF DECEASED (Type or print) Albert Raymond Hennies		4 DATE OF DEATH 3 30 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 19 April 1901
9 AGE (in years last birthday) 65 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yardmaster	
10b KIND OF BUSINESS OR INDUSTRY R. R.		11 BIRTHPLACE (State or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME Carl Frederick Hennies	
14 MOTHER'S MAIDEN NAME Lela Ann Holland		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT William F. Hennies Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 10 yrs.			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 8)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)
20f (City or town)		(County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kenoe, M.D. M.D.		22. DATE SIGNED 3-31-67	
EXAMINER'S NAME (Type) John Kenoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 4/3/67	23c NAME OF CEMETERY OR CREMATORY Fort Lincoln	23d LOCATION (City or Town) (County) (State) Bladensburg Md
24 FUNERAL DIRECTOR ADDRESS Lee Funeral Home Washington, D.C.		25a REC'D BY REG STRAP DATE APR 3 1967	25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

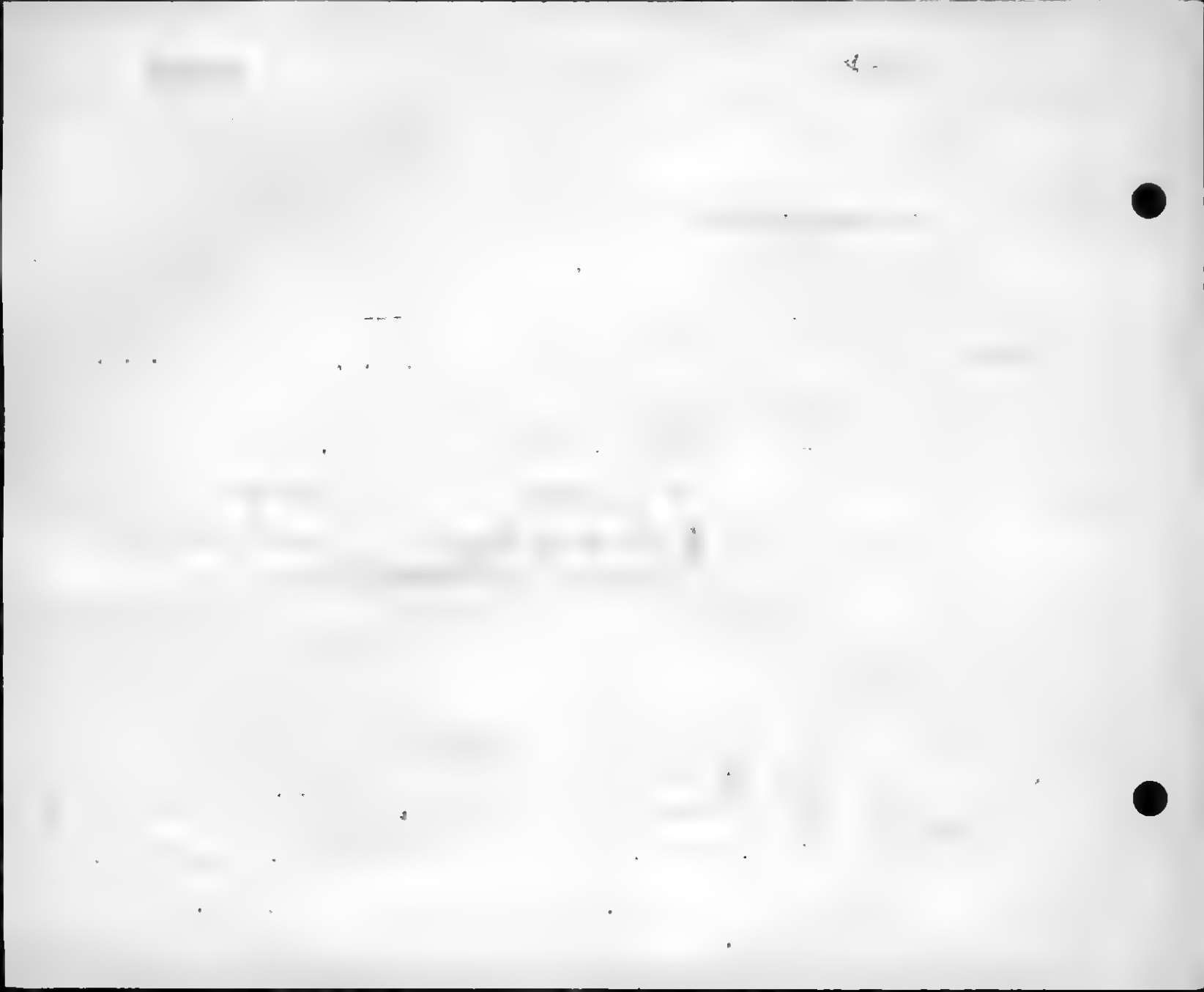
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04073

CERTIFICATE OF DEATH

04072

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5901 Lockwood Road			
3. NAME OF DECEASED (Type or print) First Helen Middle F. Last Hines				4. DATE OF DEATH Month March Day 13 Year 19 67			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/20/1899	
				9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (County & State, or foreign country) Wash., D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Widmire				14. MOTHER'S MAIDEN NAME Elizabeth Wall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO 053-18-2009			
17. INFORMANT Mr. Charles W. Hines (above address)				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction (son) 4201 DUE TO Arteriosclerosis heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 March 13 , 19 67 , that (I) (we) last saw the deceased alive on March 13 , 19 67 , and that death occurred at 4:37 M. from causes and on the date stated above.							
22a. SIGNATURE William C. Weintraub				22b. DATE SIGNED March 16, 1967			
22c. PHYSICIAN'S NAME (Type) William C. Weintraub, M.D.				22d. ADDRESS Professional Bldg. Greenbelt, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/16/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Wash., D.C.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				25. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

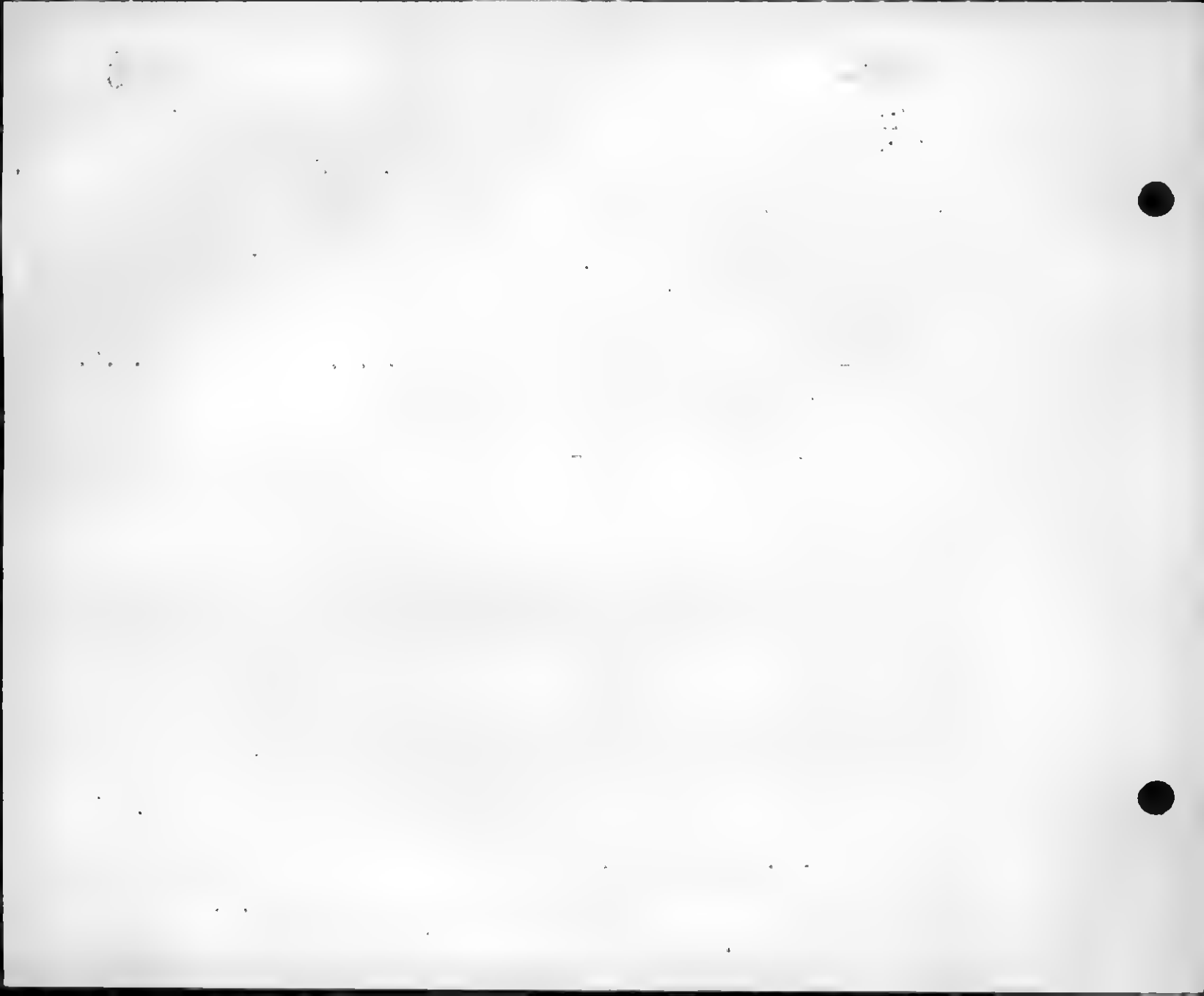
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04074

CERTIFICATE OF DEATH

04073

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
c LENGTH OF STAY IN 1b 12 1/2 hrs		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d STREET ADDRESS 4219 30th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Edgar K. Hodges		4 DATE OF DEATH Month March Day 26 Year 67	
5 SEX Male	6 COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-25-94
9 AGE (In years) 72 (birth day) yrs.		10 IF UNDER 1 YEAR Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bell Hop - Lee House - Retired		12 KIND OF BUSINESS OR INDUSTRY Wash., D.C.	
13 BIRTHPLACE (County & State, or foreign country) U.S.A.		14 CITIZEN OF WHAT COUNTRY?	
15 FATHER'S NAME George H. Hodges		16 MOTHER'S MAIDEN NAME Mary Otts	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		18 SOCIAL SECURITY NO. 577-03-9939	
19 INFORMANT Mrs. Annie Hodges		Address (above address)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ① Cardio-circulatory collapse DUE TO (b) ② Severe malnutrition, chronic DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-26 , 19 67 , to 3-26 , 19 67 , that (I) (we) last saw the deceased alive on 3-26 , 19 67 and that death occurred at 10:10 PM , from causes and on the date stated above.			
22a. SIGNATURE R. U. FRANCHI		22b. DATE SIGNED 3/28/67	
22c. PHYSICIAN'S NAME (Type) R. U. FRANCHI, M.D.		22d. ADDRESS 7729 Finn's Lane Lanham Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/29/67	23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	23d. LOCATION (City or Town) (County) (State) Wash., D.C.
24. FUNERAL DIRECTOR Nalloy's		25a. REC'D BY REGISTRAR 100 Charles Judge	
Funeral Home Inc. Maryland		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

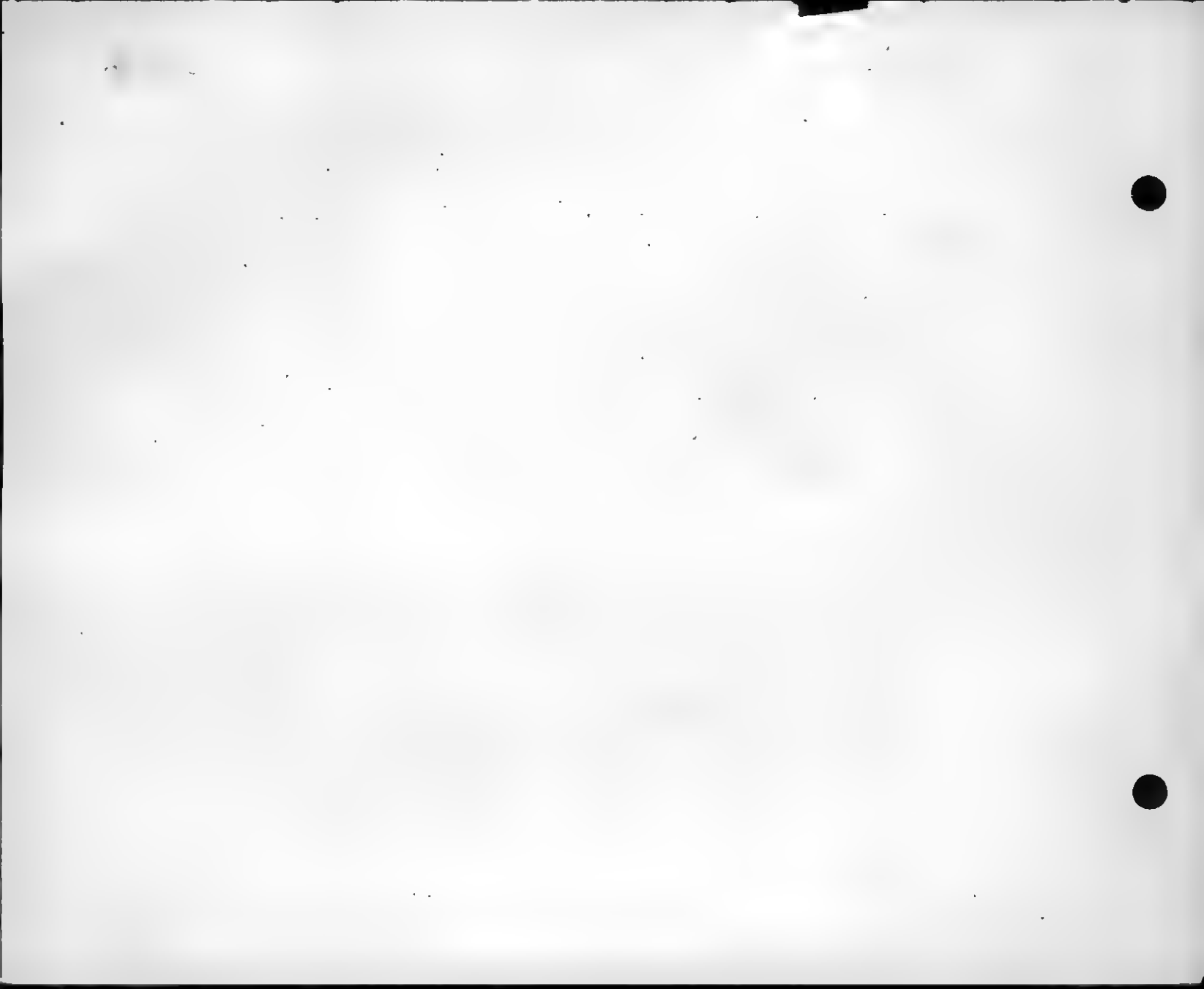
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04075

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04074

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>4812 Edmondeston Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Leland Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry Lee</u> Middle <u>Howard</u> Last <u>Howard</u>		4. DATE OF DEATH Month <u>3</u> Day <u>5</u> Year <u>1967</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-87</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>15</u> Min.	IF UNDER 24 HRS. Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Howard</u>				14. MOTHER'S MAIDEN NAME <u>Symphonia Simpson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>577-61-0127A</u>		17. INFORMANT <u>Wife, ELEANOR HOWARD</u>		Address <u>Same AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>Haul</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GEN. ARTERIOSCLEROSIS</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-27</u> , 19 <u>64</u> , to <u>3-5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-28</u> 19 <u>67</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>C.J. Houmann</u>				22b. DATE SIGNED <u>3-5-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>C.J. HOUMANN</u>				22d. ADDRESS <u>RIVERDALE MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAR. 8 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BLADENBURG, MD.</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO</u>				25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>RIVERDALE, MD.</u>							

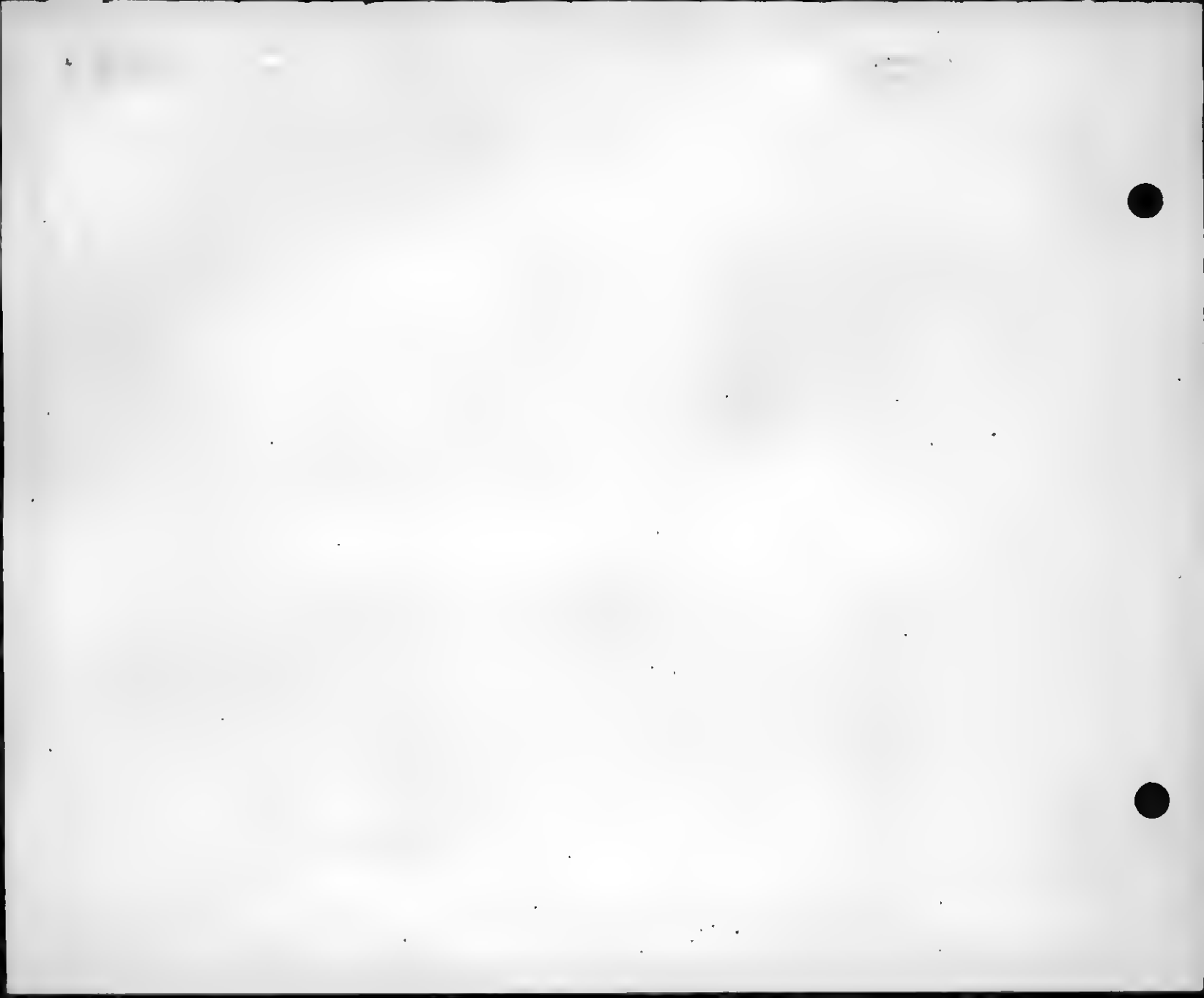


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04076 CERTIFICATE OF DEATH 04075

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARLOW HEIGHTS		c. LENGTH OF STAY IN 1b 4 1/2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARLOW HEIGHTS	
		d. STREET ADDRESS 6204-Dallas Place.	
3. NAME OF DECEASED (Type or print) GIOVANNINA IASCONI		4. DATE OF DEATH Month MARCH Day 31 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 10, 1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME JOHN BATTISTA		14. MOTHER'S MAIDEN NAME ROSA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 579-05-0682	
17. INFORMANT KATHERINE IASCONI		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE Heart Failure 4/200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 2 months 6 to 2 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from MARCH, 1967 , to MAR. 30, 1967 , that (I) (we) last saw the deceased alive on MAR. 30 1967 , and that death occurred at 2:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE Max E. Feldman MD		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) MAX E. FELDMAN M.D.		22d. ADDRESS 5721-Temple Hills Road P.O. Box 9	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/3/67	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City, town or county) (State) PRINCE GEORGES, MARYLAND	
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME		25a. REC'D BY REGISTRAR APR 3 1967	
4308 SUITLAND ROAD, SUITLAND, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04077

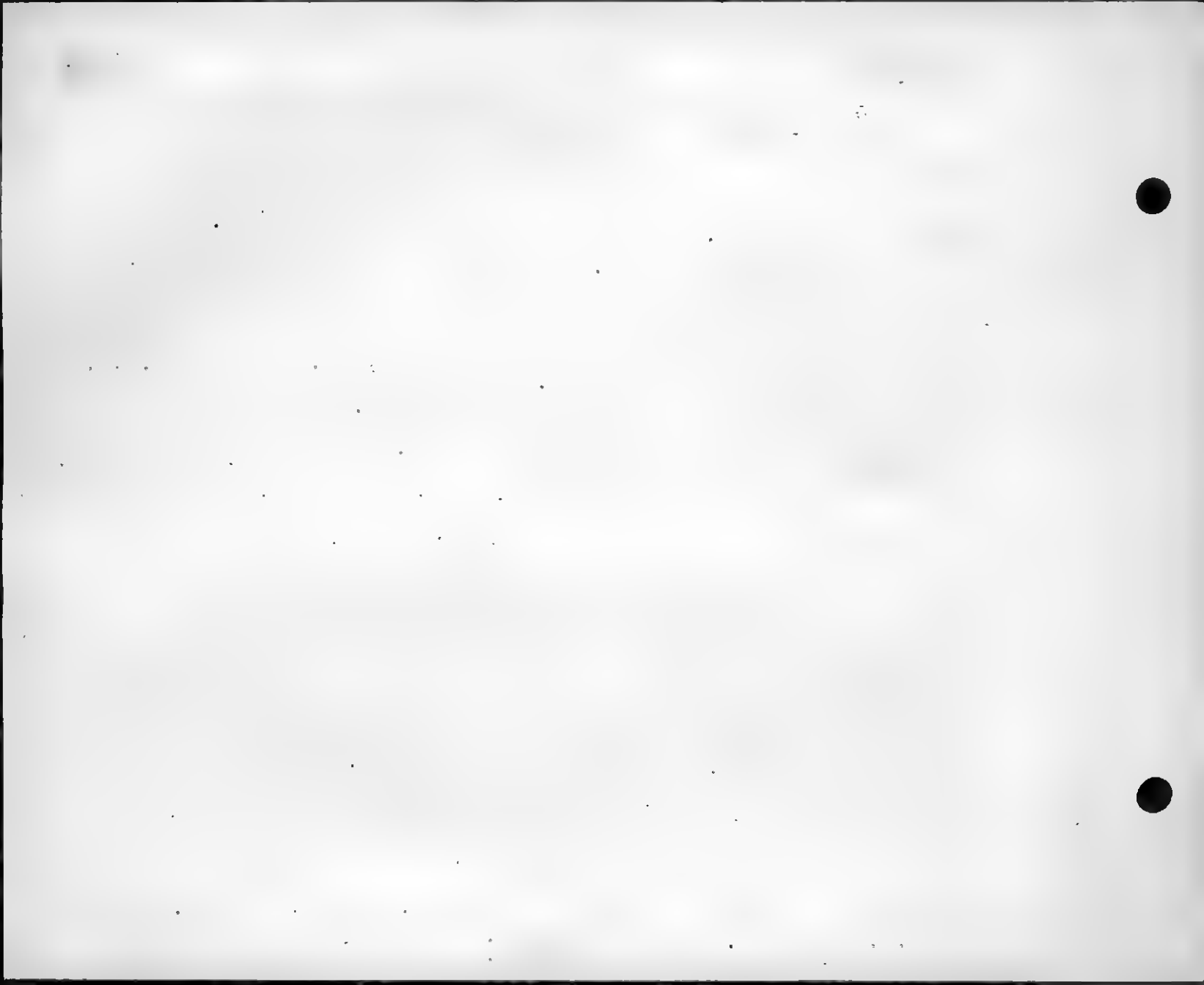
CERTIFICATE OF DEATH

04076

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Chester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>				c. LENGTH OF STAY IN 1b <u>2010 Greenbelt Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greenbelt Convalescent Center</u>				d. STREET ADDRESS <u>24th & Crosby Sts.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>W.</u> Last <u>Jester</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/28/90</u>	
9. AGE (In years last birthday) <u>76</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant & officer Manager-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chester, Pa.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Alfred William Jester</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah E. Knott</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>195-05-4206</u>				17. INFORMANT <u>Walter H. Jester</u> Address <u>4015 Van Duren St. University Park, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> DUE TO <u>Partial Respiratory Paralysis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Arteriosclerotic Cerebrovascular disease</u> DUE TO (c) <u>Severe Arteriosclerotic Cerebrovascular disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>67</u> to <u>March</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>March</u> , 19 <u>67</u> , and that death occurred at <u>10:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William A. Wimsatt</u>				22b. DATE SIGNED <u>10 March 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>William A. Wimsatt, MD</u>				22d. ADDRESS <u>3415 Hamilton St, Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>3/10/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chester Rural Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Chester, Pa.</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>				25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

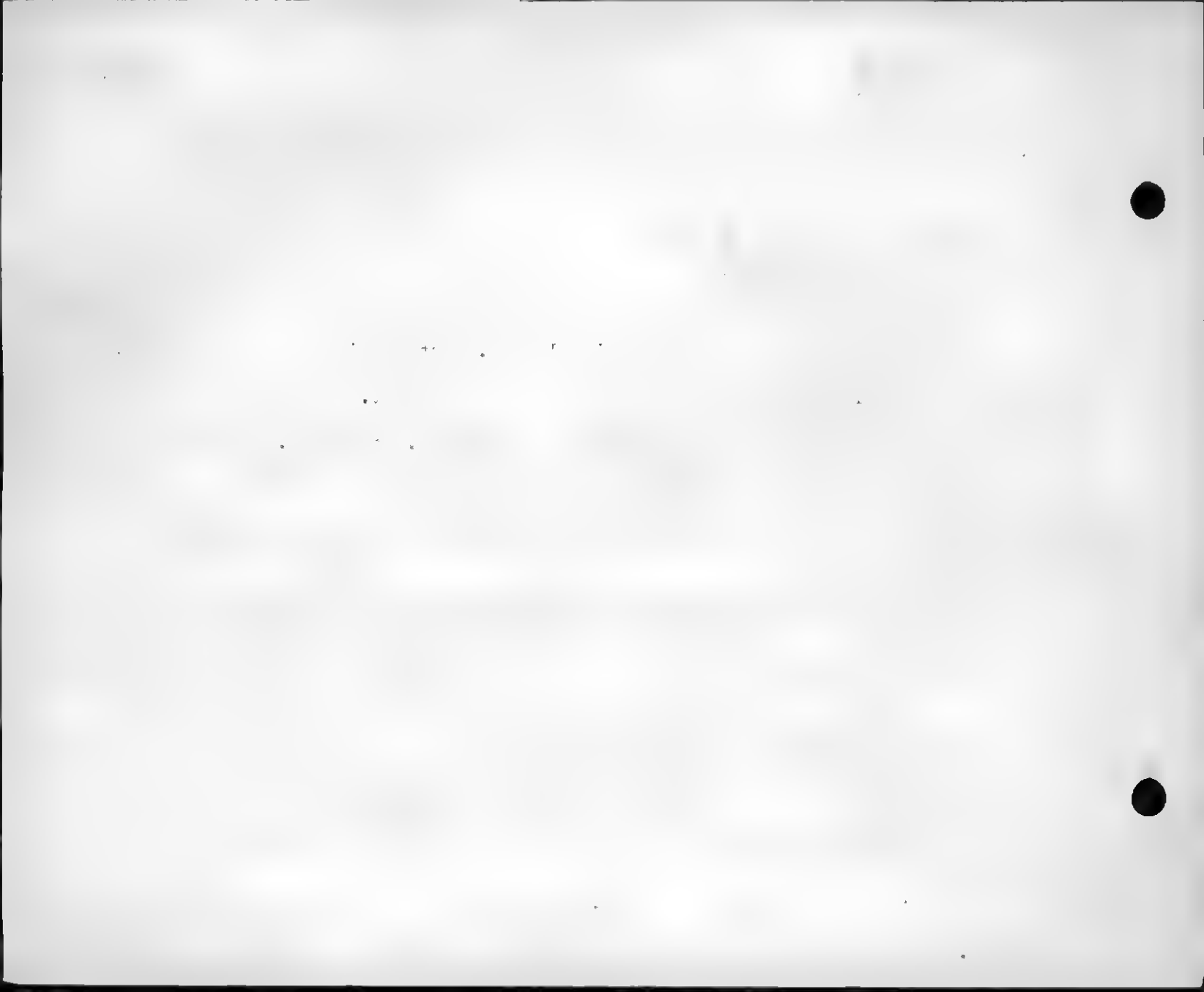
04078

CERTIFICATE OF DEATH

04077

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 65 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 222 73rd Street	
3. NAME OF DECEASED (Type or print) First Middle Last Kathryn L Jewell		4. DATE OF DEATH Month Day Year March 12 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Dec., 1923
9. AGE (In years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY International Asso. West Virginia	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ira Bliss Stone		14. MOTHER'S MAIDEN NAME Nellie T. Hagan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT William H. Jewell Jr.		Address Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Terminal CA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Multiple Pulmonary emboli DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 4, 1967 , to March 12, 1967 , that (I) (we) last saw the deceased alive on March 12, 1967 , and that death occurred on March 12, 1967 from causes and on the date stated above.			
22a. SIGNATURE Saul Schwartzbach		22b. DATE SIGNED March 13, 1967	
22c. PHYSICIAN'S NAME (Type) Saul Schwartzbach, M.D.		22d. ADDRESS 1726 Eye St. Washington, D.C. 20006	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/17/1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	23d. LOCATION (City or Town) (County) (State) Bladensburg Maryland
24. FUNERAL DIRECTOR W.W. CHAMBERS CO.		25a. BY REGISTRAR 75a. REGISTRAR'S SIGNATURE	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04079

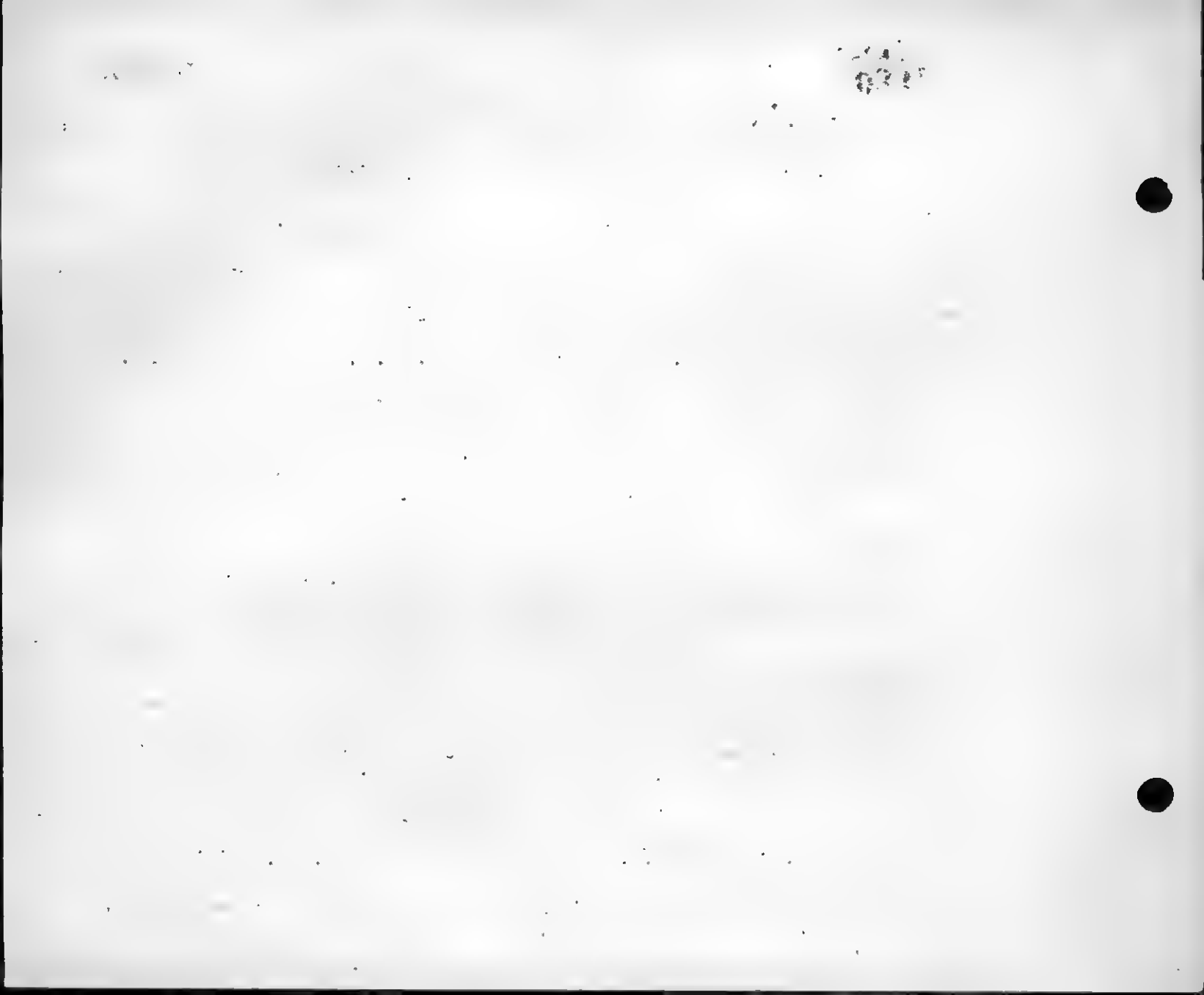
CERTIFICATE OF DEATH

D4078

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY in 1b 7 hrs	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d STREET ADDRESS 3810 32nd St.	
3 NAME OF DECEASED (Type or print) First Middle Last Emily P Johnson		4. DATE OF DEATH Month Day Year March 23 19 67	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 26 April 1900
9 AGE (in years last birthday) 66 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Western Union Tele. Co. - Retired		10b. KIND OF BUSINESS OR INDUSTRY Wash., D.C.	
11. BIRTHPLACE (County & State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles J. Peckham		14. MOTHER'S MAIDEN NAME Mabel A. Haskins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-22-2525	
17. INFORMANT Address Mr. Paul D. Johnson (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac arrest (Husband) DUE TO (b) Myocardial infarction DUE TO (c) Acute coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 18 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) was hospitalized attended the deceased from July 15, 19 64 to March 23, 19 67 , that (I) last saw the deceased alive on March 23, 19 67 , and that death occurred at 5.30 AM , from causes and on the date stated above			
22a SIGNATURE Don B. Cameron M.D.		22b. DATE SIGNED 3-24-67	
22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.		22d ADDRESS 3503 Perry St. Mt. Rainier, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR Charles Judge DATE MAR 28 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04080

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04079

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f. institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN It DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Box 143	
3 NAME OF DECEASED (Type or print) First Middle Last James Ernest Johnson		4 DATE OF DEATH Month Day Year 3 28 19 67	
5 SEX male	6 COLOR OR RACE negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 29 Dec. 1892
9 AGE (in years lost birthday) 74		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Georgia	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Unknown	
14 MOTHER'S MAIDEN NAME Sarah Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Not Stated	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mr. Roosevelt Johnson (Same as Above) SON	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d INJURY OCCURRED Where <input type="checkbox"/> not where <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md.		22 DATE SIGNED 3-28-67	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4/3	
23c. NAME OF CEMETERY OR CREMATORY Church		23d. LOCATION (City or town) (County) (State) Glennview Md	
24 FUNERAL DIRECTOR John T. Rhines & Company		25a. REC'D BY REGISTRAR APR 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1947



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04081

04080

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND		c. LENGTH OF STAY IN 1D	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. ANDREW'S AIR FORCE BASE HOSPITAL					
3. NAME OF DECEASED (Type or print) WILLIAM REED JOHNSTONE		4. DATE OF DEATH Month MAR Day 18 Year 1967		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH JAN 16 1946		9. AGE (In years last birthday) 21 yrs.		10. IF UNOER 1 YEAR Months 2 Days 1 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LANCER CORPORAL		10b. KIND OF BUSINESS OR INDUSTRY U.S.M.C.		11. BIRTHPLACE (State or foreign country) ST. CLOUD MINNESOTA	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME EARL F. JOHNSTONE		14. MOTHER'S MAIDEN NAME IDA MAY UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. U.S.M.C. ACTIVE 477548770		17. INFORMANT ANDREW'S AIR FORCE BASE RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN DAMAGE 5254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Secondary to Skull Fracture DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH AUTO ACCIDENT		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2:30 p.m. 3-18-1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dayton O Watkins		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-19-67	
EXAMINER'S NAME (Type) DAYTON O WATKINS		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 3-19-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/21/67		23c. NAME OF CEMETERY OR CREMATORY Fort Snelling Nat'l	
23d. LOCATION (City, town or county) ST Paul, MINNESOTA		(State)			
24. FUNERAL DIRECTOR W.W. Chambers Co Inc.		ADDRESS 1400 Chapin St. N.E.		25a. REC'D BY REGISTRAR MAR 23 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

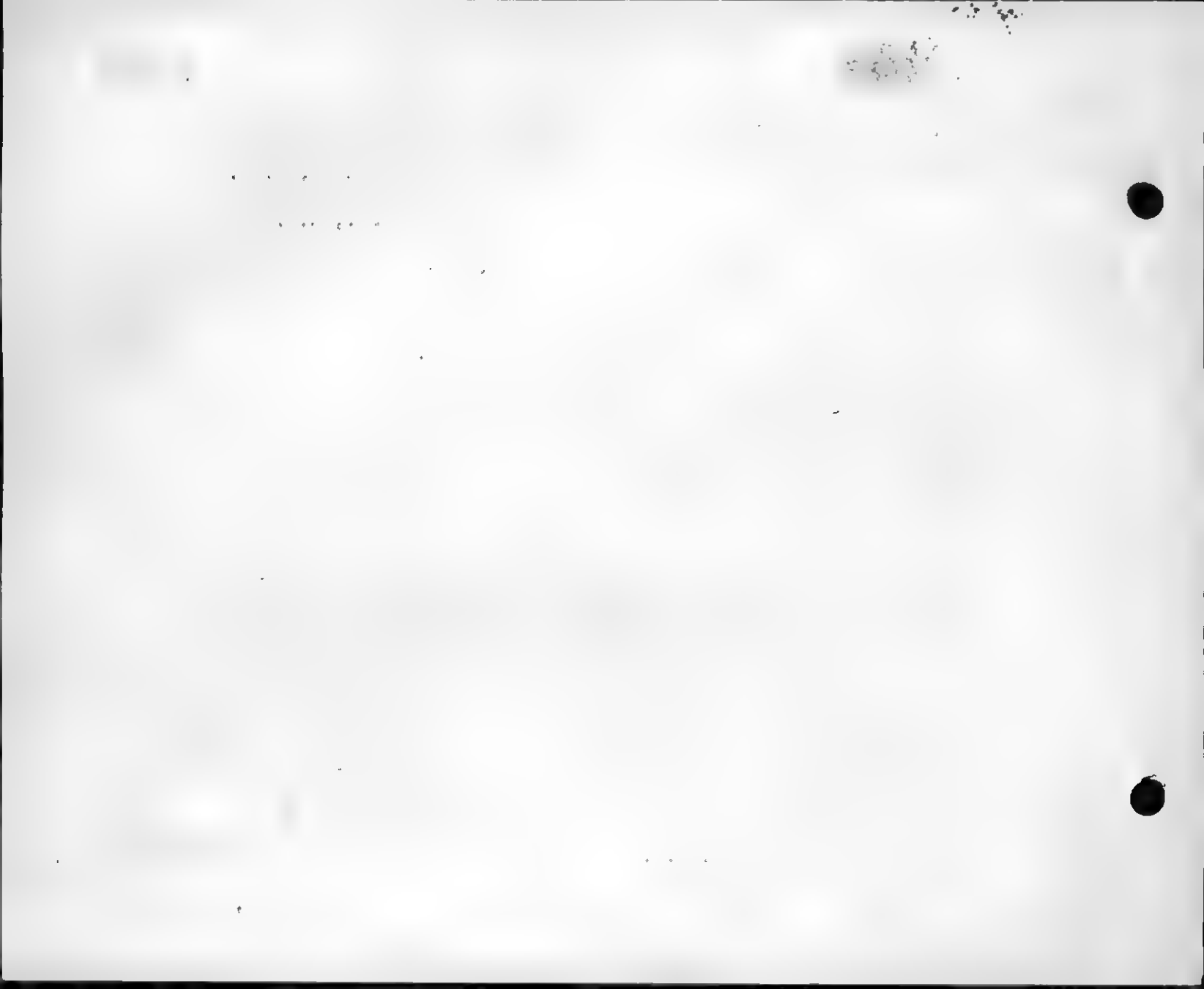
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04082

CERTIFICATE OF DEATH

04081

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.	
c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1765 You St., N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nelson Middle Jones Last Jones		4. DATE OF DEATH Month March Day 24 Year 1967	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/02
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 24 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Jones		14. MOTHER'S MAIDEN NAME Nora ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, massive, left lung DUE TO (b) Carcinoma with massive lymph node metastases, DUE TO (c) primary site undetermined (possibly urinary bladder)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic ulcer; chronic alcoholism with chronic brain syndrome		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from 2/15/1967 to 3/24/1967 , that (B) (we) last saw the deceased alive on 3/24/1967 , and that death occurred at 12:55AM from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 3/24/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/29/1967	23c. NAME OF CEMETERY OR CREMATORY Harmony	23d. LOCATION (City or Town) (County) (State) Landover, Maryland
24. FUNERAL DIRECTOR W. E. Jarvis Co 1432 You St NW		25a. REC'D BY REGISTRAR MAR 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04083

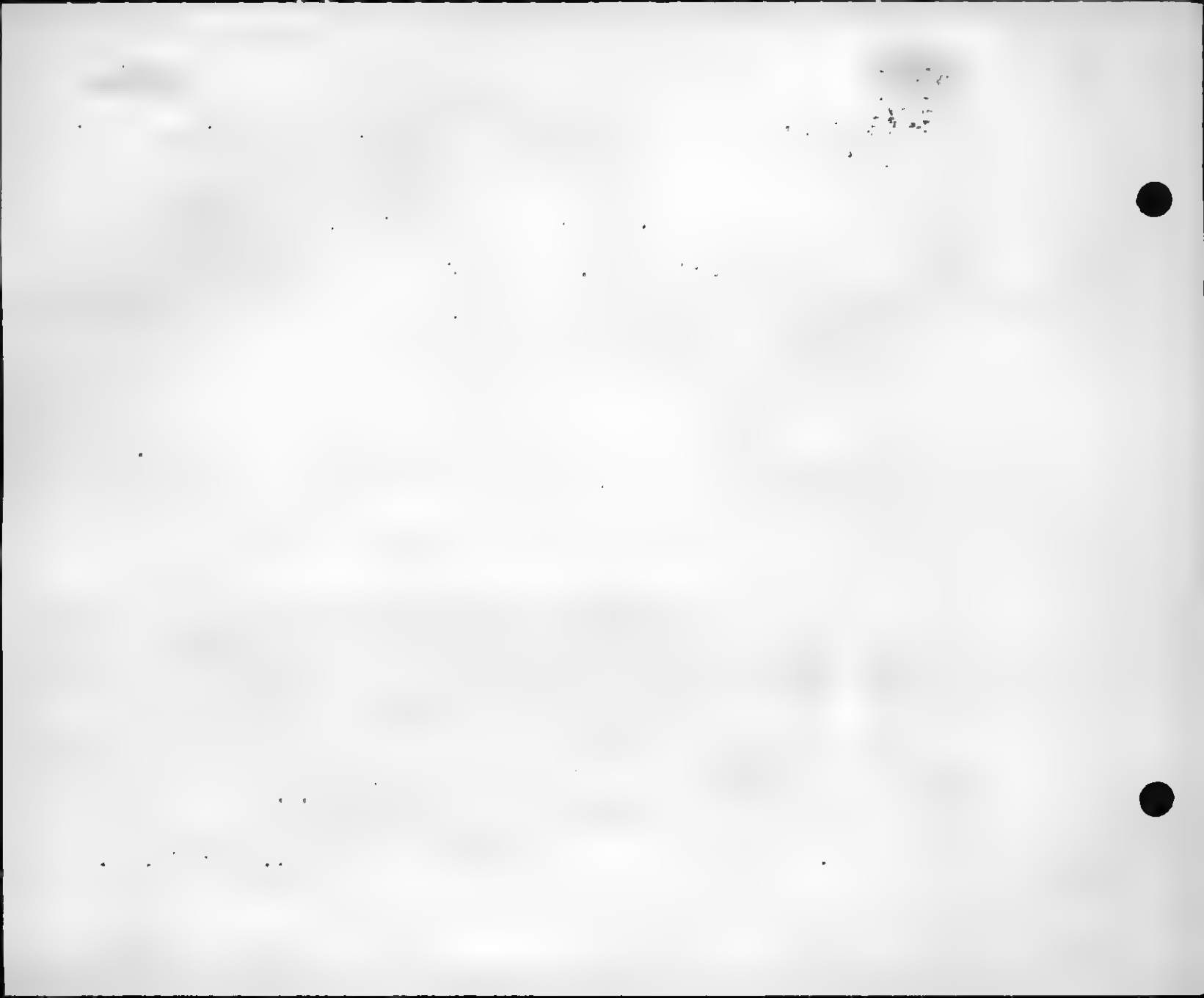
CERTIFICATE OF DEATH

04082

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b One day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Octavia M. Kagle		4. DATE OF DEATH Month Day Year March 6 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/89
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME Joseph Hacher		14. MOTHER'S MAIDEN NAME Ella Sneade	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Miriam K Vermillion		Address Lanham, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Thrombus Pt. coronary artery (Recent) 4201 DUE TO (b) Severe generalized atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 64 , to March 6, 1967 , that (I) (we) last saw the deceased alive on March 6 19 67 , and that death occurred at 12:30M , from causes and on the date stated above.			
22a. SIGNATURE Albert Roth		22b. DATE SIGNED P.M. 3-6-67	
22c. PHYSICIAN'S NAME (Type) Dr. Albert Roth		22d. ADDRESS 5409 Riverdale Rd., Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 13 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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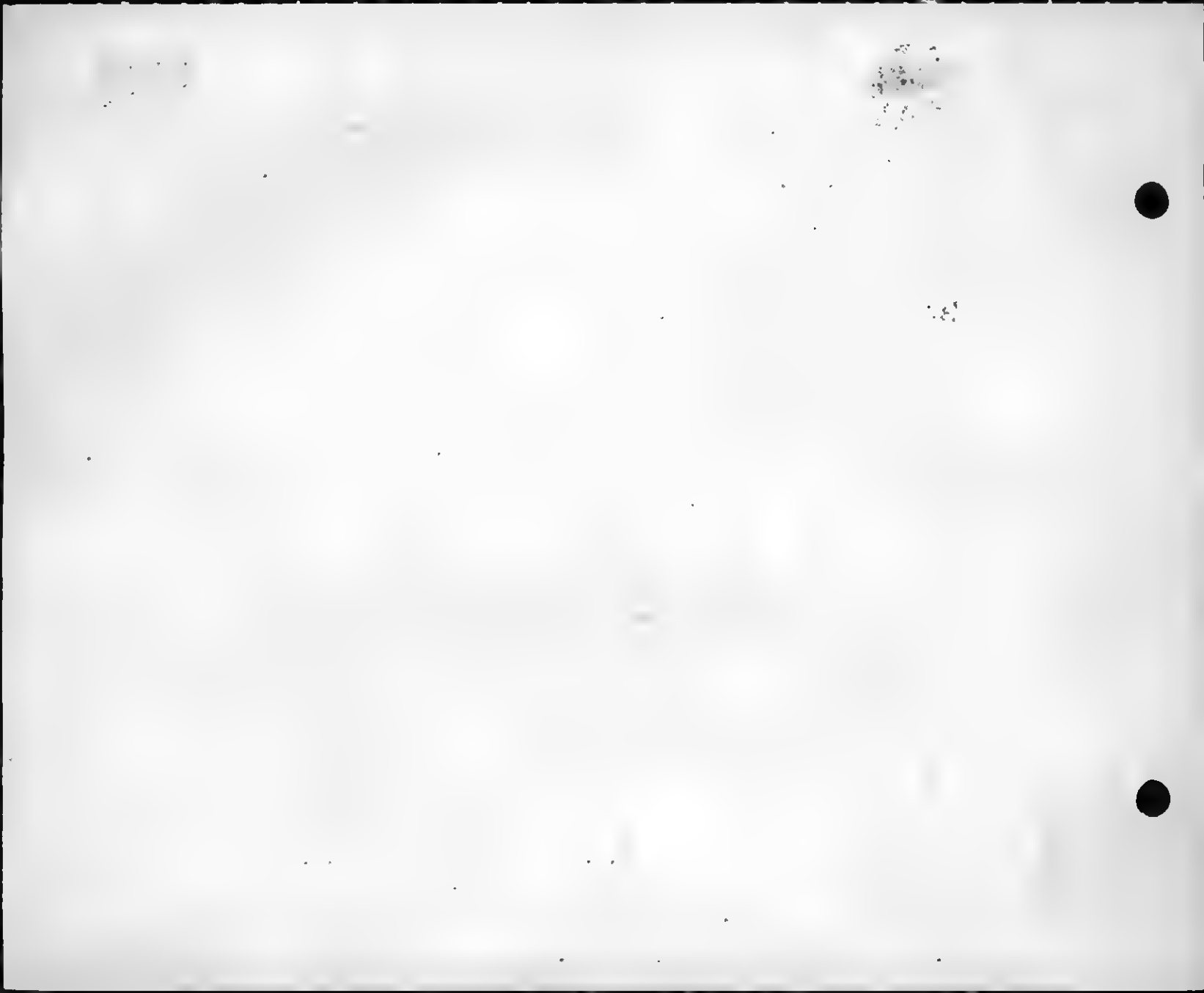
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04084

CERTIFICATE OF DEATH

04083

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. College Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4922 La Salle Road Carroll Manor Home		d. STREET ADDRESS 4323 Rowalt Dr. 4922 La Salle Road	
3. NAME OF DECEASED (Type or print) First Helen Middle R. Last Kellerman		4. DATE OF DEATH Month March Day 10 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1898
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas Wallace		14. MOTHER'S MAIDEN NAME Mary Ellen Reilly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mary Jane Kellerman		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary Thrombosis with Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis 9 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) XXXXXX attended the deceased from Feb. 5 , 19 67 , March 9 , 19 67 , that (1) the last saw the deceased alive on 3/9/ 1967 , and that death occurred at 10:23 am from causes and on the date stated above.			
22a. SIGNATURE Thomas F Collins		22b. DATE SIGNED March 10, 1967	
22c. PHYSICIAN'S NAME (Type) Thomas F Collins, M.D.		22d. ADDRESS 322 H St. N.E. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 14, 1967	23c. NAME OF CEMETERY OR REMOVAL Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Va.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 13 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 67

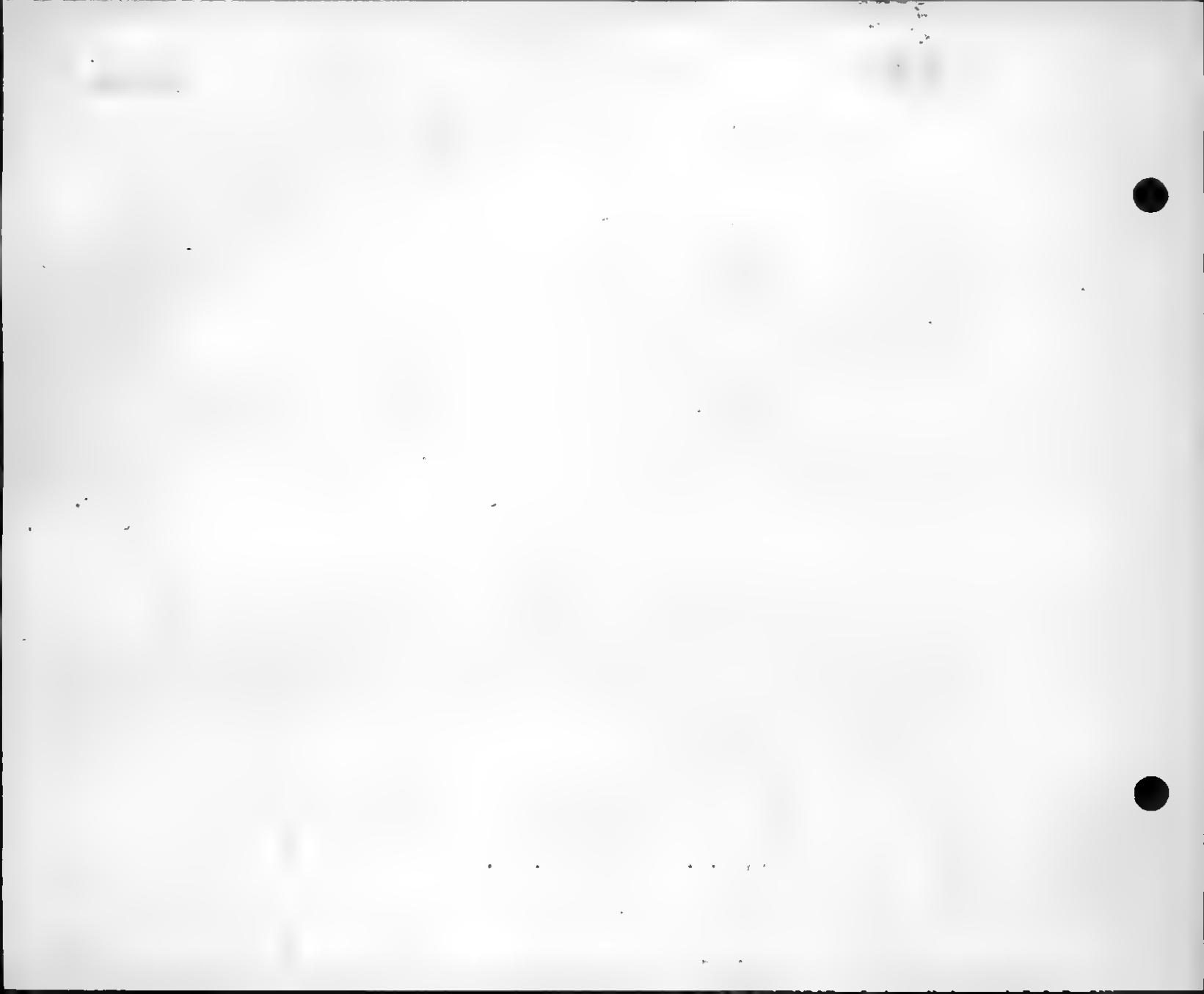
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04085

04084

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS 2725 Keystone Lane	
3. NAME OF DECEASED (Type or print) First Middle Last Lucille Veronica Kelly		4 DATE OF DEATH Month Day Year 3 6 19 67	
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-13-1903
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) New York City		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Thomas Malloy		14 MOTHER'S MAIDEN NAME XXXXX ?Bridget Golden	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO ?????	
17 INFORMANT Walter B. Cooke Funeral Home Bronx, N.Y.		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO Pulmonary emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 1 yr. over 3 yrs.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o m p m 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22 DATE SIGNED 3-7-67	
23a BURIAL CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF 3/19/67	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d LOCATION (City or town) (County) (State) Mt. Pleasant, N.Y.
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. Baltimore, Md. 21202		25a REC'D BY REGISTRAR MAR 13 1967 25b REGISTRAR'S SIGNATURE J Charles Judge	



FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04086

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04085

1 PLACE OF DEATH a COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) a STATE Maryland b. COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md.		c LENGTH OF STAY IN 1b 16.1	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e STREET ADDRESS 3809 Volta Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last Nina B. Kidwell		4 DATE OF DEATH Month Day Year March 17, 19 67	
5 SEX female	6 CO. OR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov 20, 1893
9 AGE (in years last birthday) 73 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		12 BIRTHPLACE (State or foreign country) Virginia	
13 FATHER'S NAME ?		14 MOTHER'S M A DEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 214 10 7655	
17 INFORMANT Richard Ashby Kidwell		Address Brentwood, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Heart disease & Thrombosis (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dayton O Watkins		22. DATE SIGNED 3-20-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Mar 21, 1967	
23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24 FUNERAL DIRECTOR F. Gasch's Sons		25 ADDRESS Hyattsville, Md.	
26 READ BY REGISTRAR DATE MAR 23 1967		27 REGISTRAR'S SIGNATURE Charles Judge	

235

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

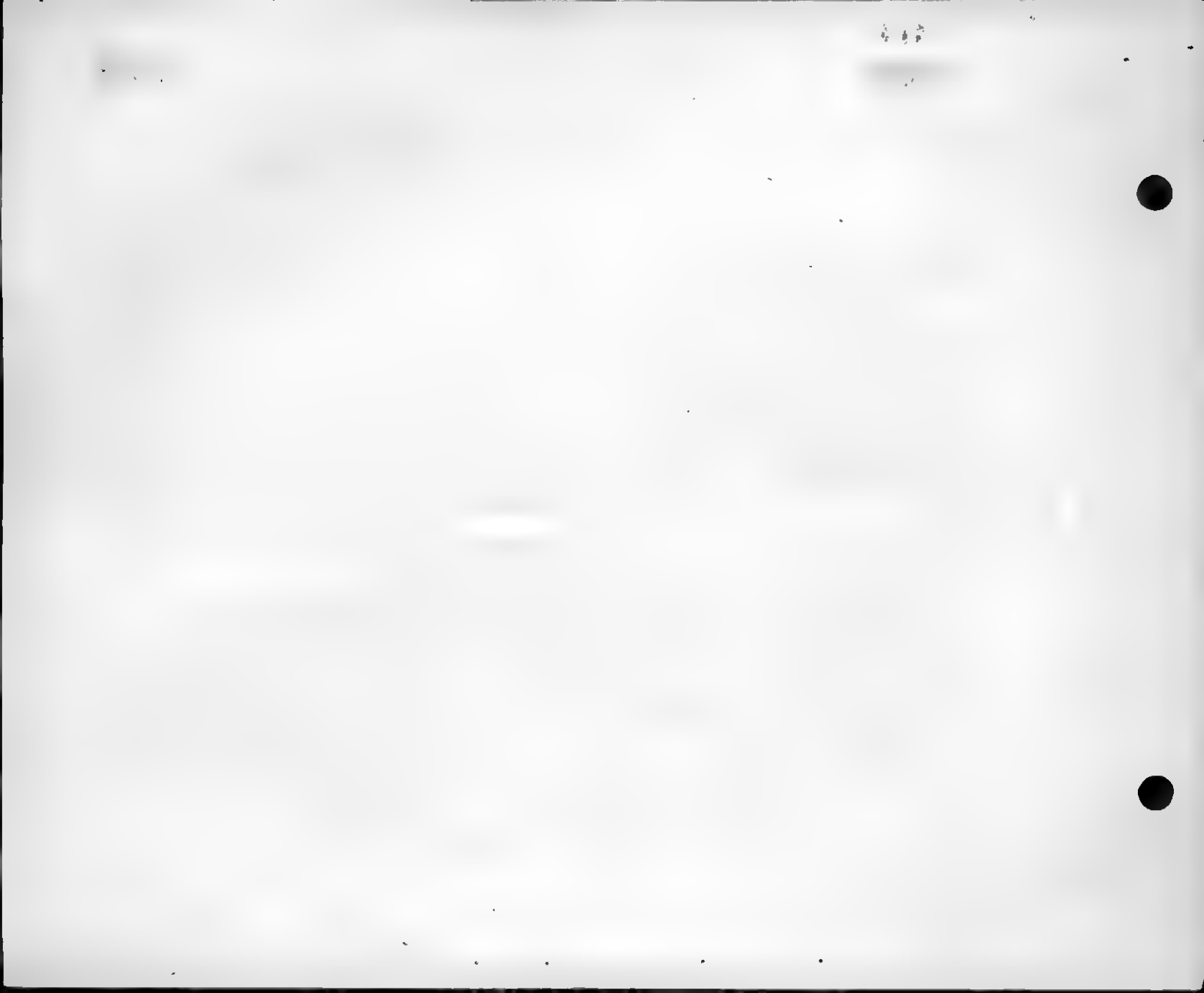
VR A15ME (5)
6M 1/66

04087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04086

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Comp Springs</u>		c. LENGTH OF STAY IN 1b <u></u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Killebrew Heights</u>		d. STREET ADDRESS <u>5011 Bellbrook Ct</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Andrews Arm Trce Base</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>JOSEPH D LA GRAVE</u>		4 DATE OF DEATH <u>March 17 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept 25 1922</u>
9 AGE (in years lost birthday) <u>44</u>		10 F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>US Gov</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Truce</u>	
11 BIRTHPLACE (State or foreign country) <u>North Dakota</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Grover Legrove</u>		14 MOTHER'S MAIDEN NAME <u>Mary H Buckley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW2</u>		16 SOCIAL SECURITY NO <u>601-186182</u>	
17 INFORMANT <u>Mrs Dallas Redshaw</u>		Address <u></u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Obtundity / Hypertension / Acute infiltration of the liver due to</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Hypertension / Arteriosclerosis / Disease</u> c) <u>Acute alcoholic intoxication</u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <u></u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dayton O Watkins</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>3-18-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>- Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros. 1661- Gd. Hope Rd. SE, Wash., DC</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04088

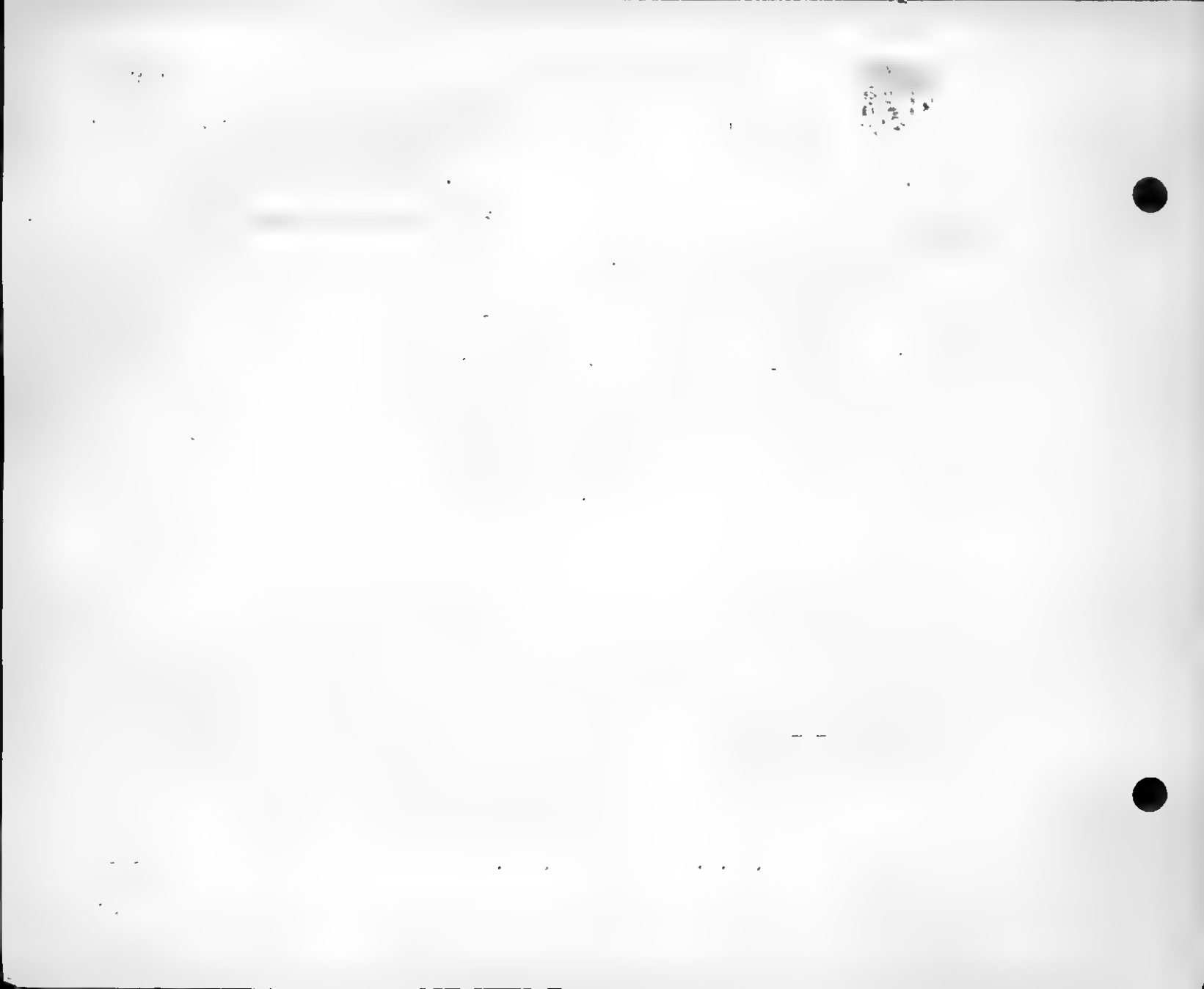
04087

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived) a STATE Maryland b COUNTY Prince George's		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			c LENGTH OF STAY IN b Mt. Rainier		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3343 Buchanan Street					
3 NAME OF DECEASED (Type or print) First Ray Middle (DARIN) Last Dearing			4 DATE OF DEATH Month 3 Day 8 Year 1967		
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 8-1-1916	9 AGE (In years last birthday) 50 yrs	10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER			10b KIND OF BUSINESS OR INDUSTRY GREY LINES		
11 BIRTHPLACE (State or foreign country) VIRGINIA			12 CITIZEN OF WHAT COUNTRY? U.S.		
13 FATHER'S NAME UNKNOWN			14 MOTHER'S MAIDEN NAME UNKNOWN		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes U.S.W. II		16 SOCIAL SECURITY NO 250 058431	17 INFORMANT SHELDAG, RICE, RT1 Box 25, HAVELOCK N.C.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 976X IMMEDIATE CAUSE (a) Gun shot wound of chest DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in chest			
20c TIME OF INJURY Month, Day, Year Hour a.m. unknown 3-3- 1967		20d INJURY <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) home	
20f (City or town) same as #2		20g (County) same as #2		20h (State) same as #2	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D.		22. DATE SIGNED 3-8-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Riverdale, Md.		Address (Street, city, town or county)	
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 14 March 1967		23c NAME OF CEMETERY OR CREMATORY ALEXANDRIA NATL. CEM.	
23d LOCATION (City or town) ALEXANDRIA, VIRGINIA		23e REC'D BY REGISTRAR 13 1967		23f REGISTRAR'S SIGNATURE J. Charles J. J.	
24 FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

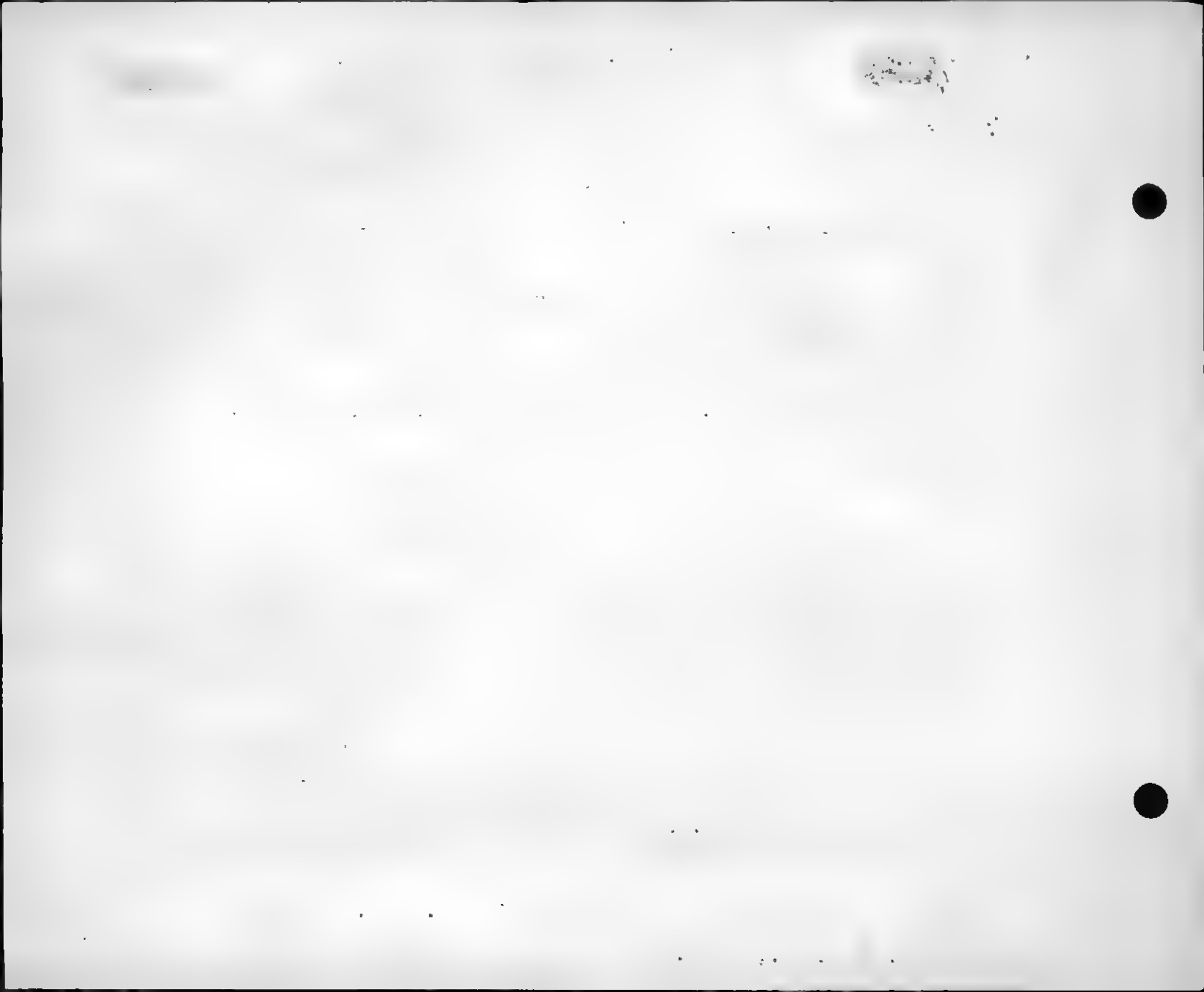
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #11 infor. taken from birth cert.

04089

CERTIFICATE OF DEATH

04088

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 hrs. 59mins	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 4263 - 58th Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last Baby Girl Lang		4 DATE OF DEATH Month Day Year March 3, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1967
9. AGE (In years lost birthday) yrs. 8		10. IF UNDER 1 YEAR Months Days Hours Min. 8 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Pr. Geo. Col., Md.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Lang, Sr.		14. MOTHER'S MAIDEN NAME Grace Frances Campbell	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 0011 Congenital Lobar Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 2, 1967 , to March 3, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 5:30 PM from causes and on the date stated above			
22a. SIGNATURE Till Bergemann, M.D.		22b. DATE SIGNED AM	
22c PHYSICIAN'S NAME (Type) Bejleum		22d ADDRESS Prof Bldg, Greenbelt, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 3/11/67	23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly PG Maryland	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland		25a REC'D BY REGISTRAR DMAR 15 1967	25b REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH


04090

04089

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek d. STREET ADDRESS Rt 1 Box 459 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth Alberta Langley				4. DATE OF DEATH Month March Day 26 Year 1967			
5. SEX Female		6. COLOR OR RACE Cau.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1899	
9. AGE (In years last birthday) 67 yrs.		10. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic			
13. FATHER'S NAME Lemuel A. Dennison				14. MOTHER'S MAIDEN NAME Ella C. Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Rt 1 Box 459 George M. Langley Sr., Accokeek, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident (b) Hypertension (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days 14 years +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 24, 1967</u>, to <u>March 26, 1967</u>, that (I) (we) last saw the deceased alive on <u>March 24, 1967</u>, and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE James C. Cawood				22b. DATE SIGNED 3-26-67		22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) JAMES CAWOOD M.D.				22e. ADDRESS 2619 Branch Ave. S.E. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Suitland, P.G., Md.	
24. FUNERAL DIRECTOR Huntt Funeral Home, Waldorf, Md.				25a. REC'D BY REGISTRAR MAR 30 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The  requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

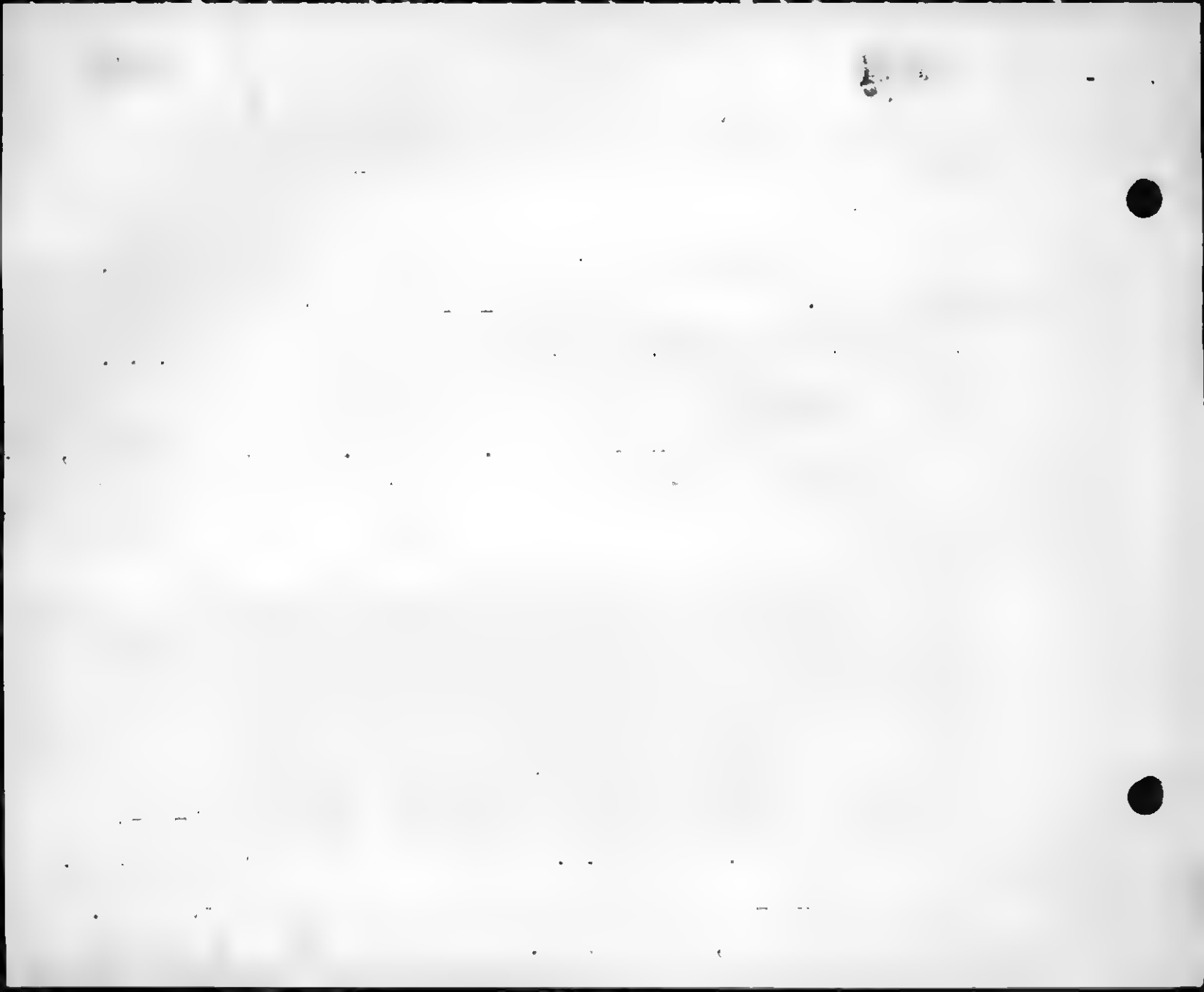
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90

2

MEICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04091						04090					
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waldorf-Rural				d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pine View Gardens						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elizabeth Kathryn Lannan			First Middle Last			4. DATE OF DEATH March 11, 1967			Month Day Year		
5. SEX Female		6. COLOR OR RACE Cau.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-10-1913		9. AGE (in years last birthday) 53 yrs.		10. IF UNDER 1 YEAR OF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY Church Rectory				11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cornelius Lannan						14. MOTHER'S MAIDEN NAME Anna Mc Crory					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 493-22-8605		17. INFORMANT Mrs. Walter A. Hudson, Los Angeles, Cal.		Address 3408 Madera			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1761 CARCINOMATOSIS DUE TO (b) ADENOCARCINOMA VAGINAL PORT. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11:20 AM, 1967, to DEATH, 1967, that (I) (we) last saw the deceased alive on 3/10 1967, and that death occurred at 5 AM, from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Merkle M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-11-67			
22c. PHYSICIAN'S NAME (Type) ROBERT W. MERKLE M.D.						22d. ADDRESS St Charles Clinic, Waldorf, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3-16-67		23c. NAME OF CEMETERY OR CREMATORY Mission Cemetery			23d. LOCATION (City, town or county) (State) Los Angeles, Calif.			
24. FUNERAL DIRECTOR Hunt Funeral Home, Waldorf, Md.						25a. REC'D BY REGISTRAR 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

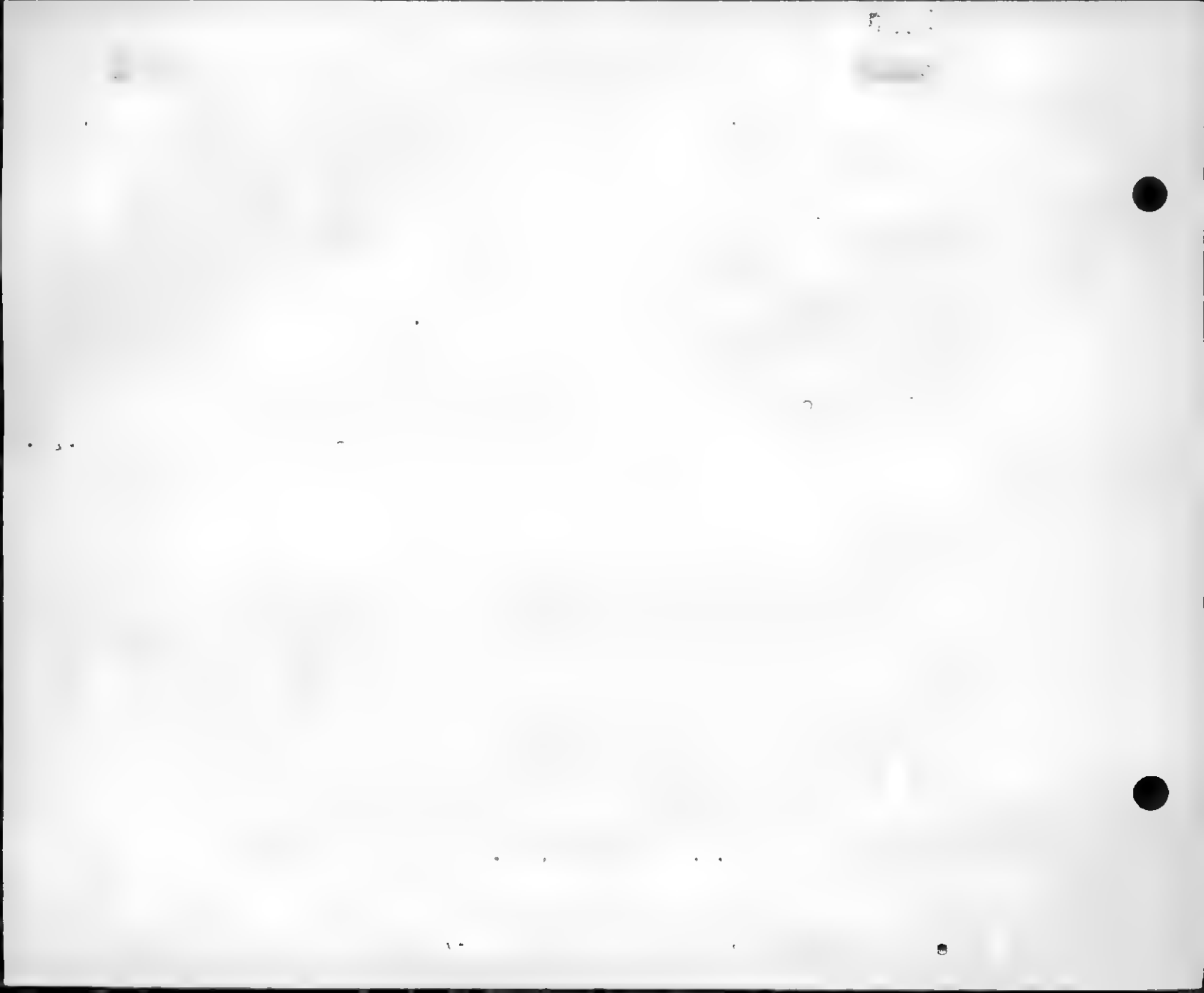
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04092

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04091

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Sadie Leonard		4 DATE OF DEATH Month Day Year 3 12 67	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 11 Nov. 1904
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 62 yrs
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Richard Brown		14 MOTHER'S MAIDEN NAME Mary Butler	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT Richard Jackson-son-6707 Eads St., N.E.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-13-67	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or town) (County) (State)
Burial	3/16/67	Harmony Memorial Park	Maryland
24 FUNERAL DIRECTOR'S NAME (Type) John T. Stewart		25a REC'D BY REGISTRAR MAR 16 1967	
Address Stewart Funeral Home-4001 Benning Rd.,		25b REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (3)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04093

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04092

1 PLACE OF DEATH a COUNTY Prince Geo.		b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN Id D.O.A.		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Pr. Geo.		c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mt. Rainier		d STREET ADDRESS 4404 - 30th St.		e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Stephen J. Liston		4 DATE OF DEATH Month March Day 19 Year 1967		5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 12/18/1900		9 AGE (In years last birthday) 66	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b KIND OF BUSINESS OR INDUSTRY Railroad		11 BIRTHPLACE (State or foreign country) Ireland		12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Donnis Liston		14 MOTHER'S MAIDEN NAME Eileen White		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO		17 INFORMANT Mrs. Florence G. Liston (above address)		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis H201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH inst		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH no		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 3-20-67			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3/22/67		23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Com.		23d LOCATION (City or Town) (County) (State) Silver Spring, Md.		24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a REC'D BY REGISTRAR MAR 23 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

ACTUAL SIGNATURE

NAME (Type)

Dayton O. Watkins
DAYTON O. WATKINS

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

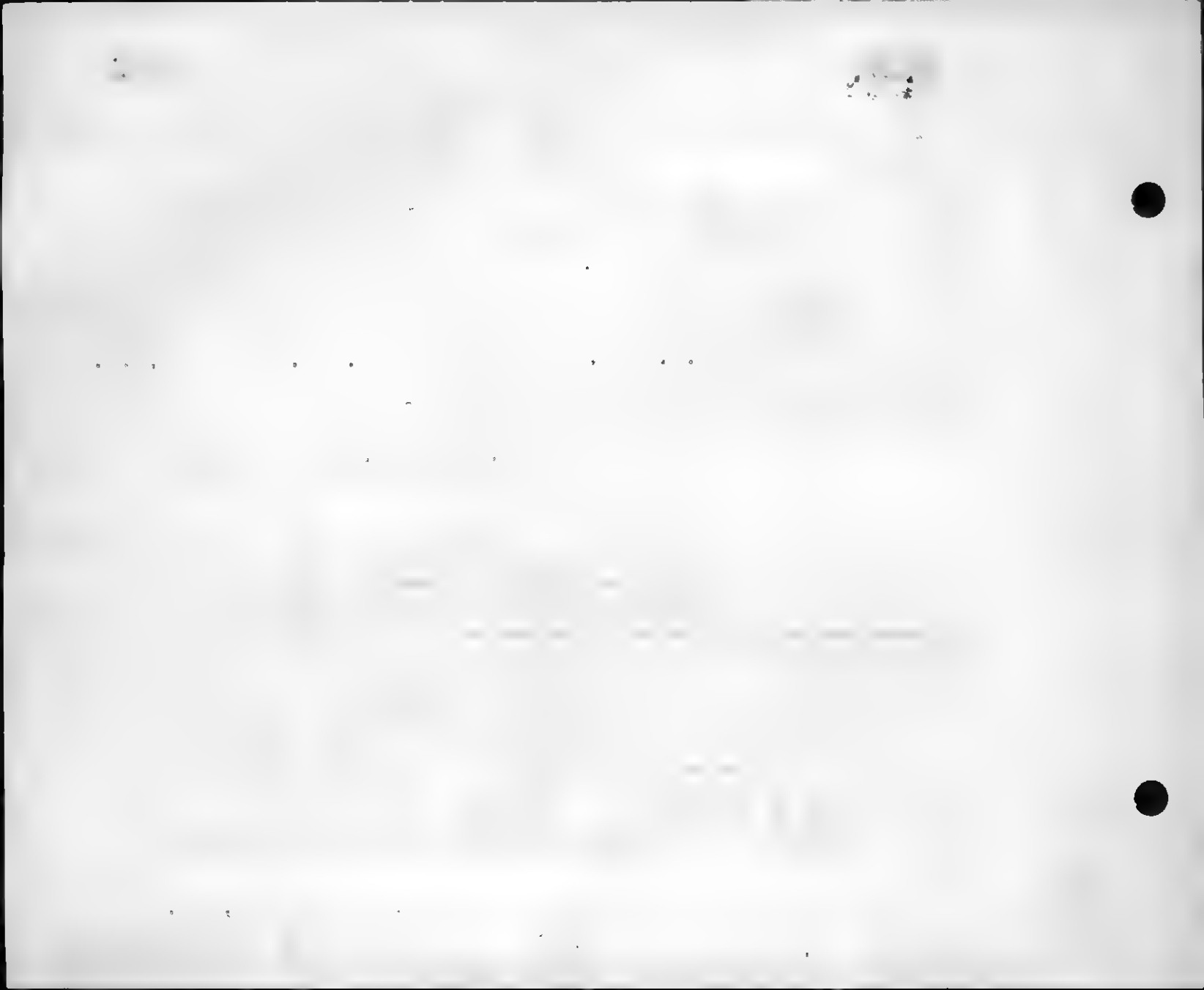
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04094

CERTIFICATE OF DEATH

04093

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN 1b 4 hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 2906 Bunker Hill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Ruth P. Little		4 DATE OF DEATH Month Day Year March 6 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/15/99
9 AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.	
11. BIRTHPLACE (County & State, or foreign country) Hinton, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Parker		14. MOTHER'S MAIDEN NAME Lucinda McVey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Harold R. Little (above address)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST, Pul. Embolism, Branch DUE TO EMPHYSEMA & LEFT PNEUMONECTOMY, Pul. Abscess, Rt. upper lobe DUE TO BRONCHOGENIC CARCINOMA DUE TO lost Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost INTERVAL BETWEEN ONSET AND DEATH 2 months. 6 months.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatomegaly, Nephrotic syndrome.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Dec 8, 1966 to MARCH 6, 1967 , that (I) (we) last saw the deceased alive on March 6 1967 , and that death occurred at 2:10 PM , from causes and on the date stated above.			
22a. SIGNATURE Roy G. Klepser		22b. DATE SIGNED 3/6/67	
22c. PHYSICIAN'S NAME (Type) ROY G. KLEPSER MD		22d. ADDRESS 1835 EYE ST NW WASHINGTON, DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/10/67	
23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Cem.		23d. LOCATION (City or Town) (County) (State) Herndon, Va.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25. REGISTERED BY REGISTRAR APR 9 1967	
26. ADDRESS Mt. Rainier Maryland		27. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #11, 12, 13 & 14 File # 3387 11/3/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04095

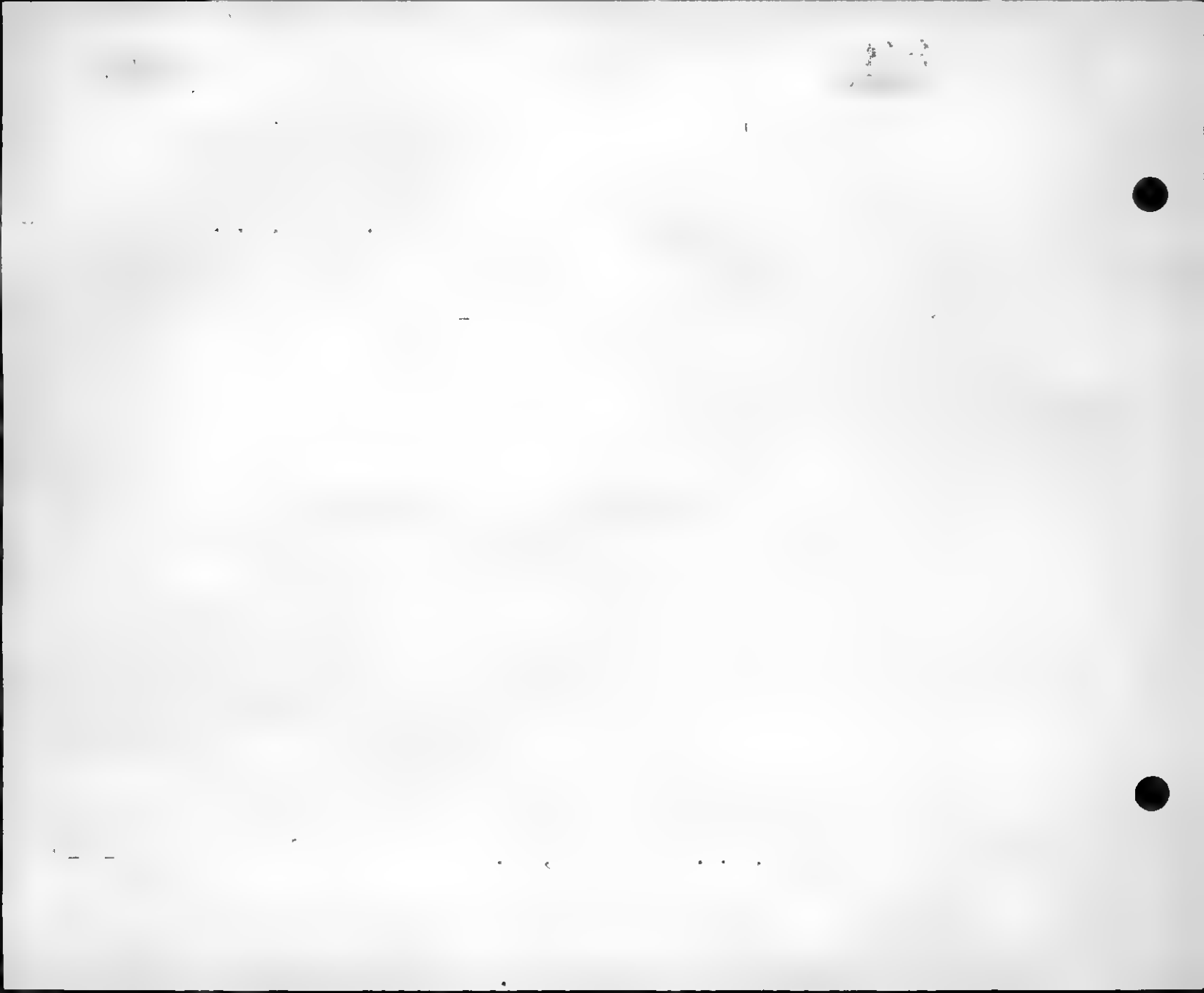
04094

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE District Of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 37 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Edward Livingston		4 DATE OF DEATH Month Day Year 3 16 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-3-1916
9 AGE (in years lost birthday) yrs 50		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) North, S.C.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Kit Livingston	
14 MOTHER'S MAIDEN NAME Henrietta Thomas		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage, left internal capsule 331X DUE TO Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 3-17-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23 BURIAL, CREMATION, REMOVAL (Specify) 3-24-67		23b DATE THEREOF 3-24-67	
23c NAME OF CEMETERY OR CREMATORY Alexander National		23d LOCATION (City or Town) (County) (State) Alexander Virginia	
24 FUNERAL DIRECTOR Universal Funeral Home		25a REC'D BY REGISTRAR MAR 27 1967	
25b REGISTRAR'S SIGNATURE J. Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04096

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

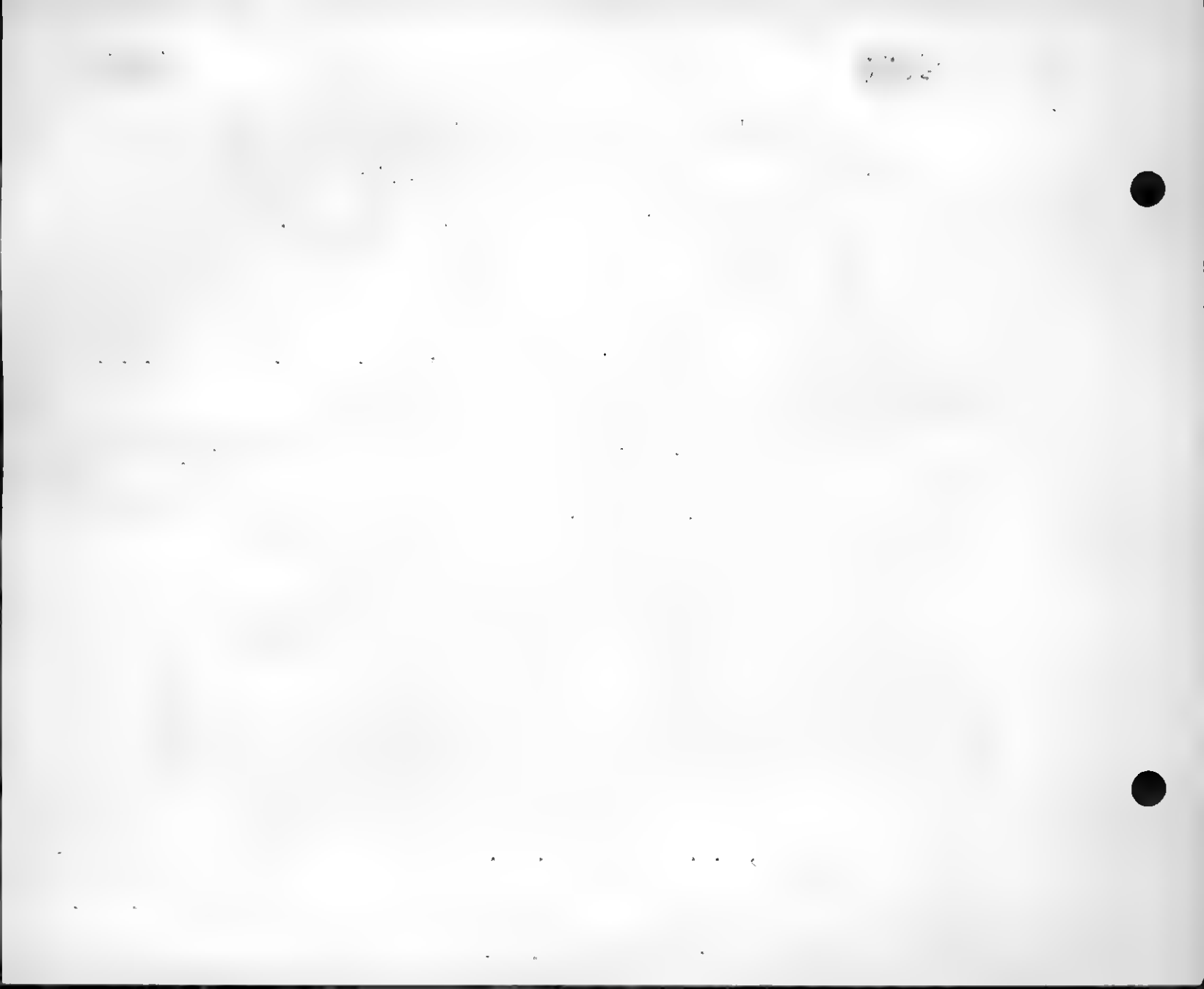
04095

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f. institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b. DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 2808 McComas Ave.	
3 NAME OF DECEASED (Type or print) George Fulton Long		4 DATE OF DEATH Month 3 Day 9 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-9-1915
9 AGE (in years last birthday) 51 yrs		10 UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Bergman's Laundry	
11 BIRTHPLACE (State or foreign country) Allentown, Penna.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Fulton Long		14 MOTHER'S MAIDEN NAME Rachel Sherrer	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No None		16 SOCIAL SECURITY NO 226-16-2543	
17 INFORMANT Mrs. Hilda Long		Address 2808 McComas Avenue Kensington, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes over 15 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-9-67	
23a. B. RIAL (CREMATION REMOVAL) (Specify) Cremation	23b. DATE THEREOF March 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	23d. LOCATION (City or town) (County) (State) Prince Georges Co., Md.
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR MAR 13 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

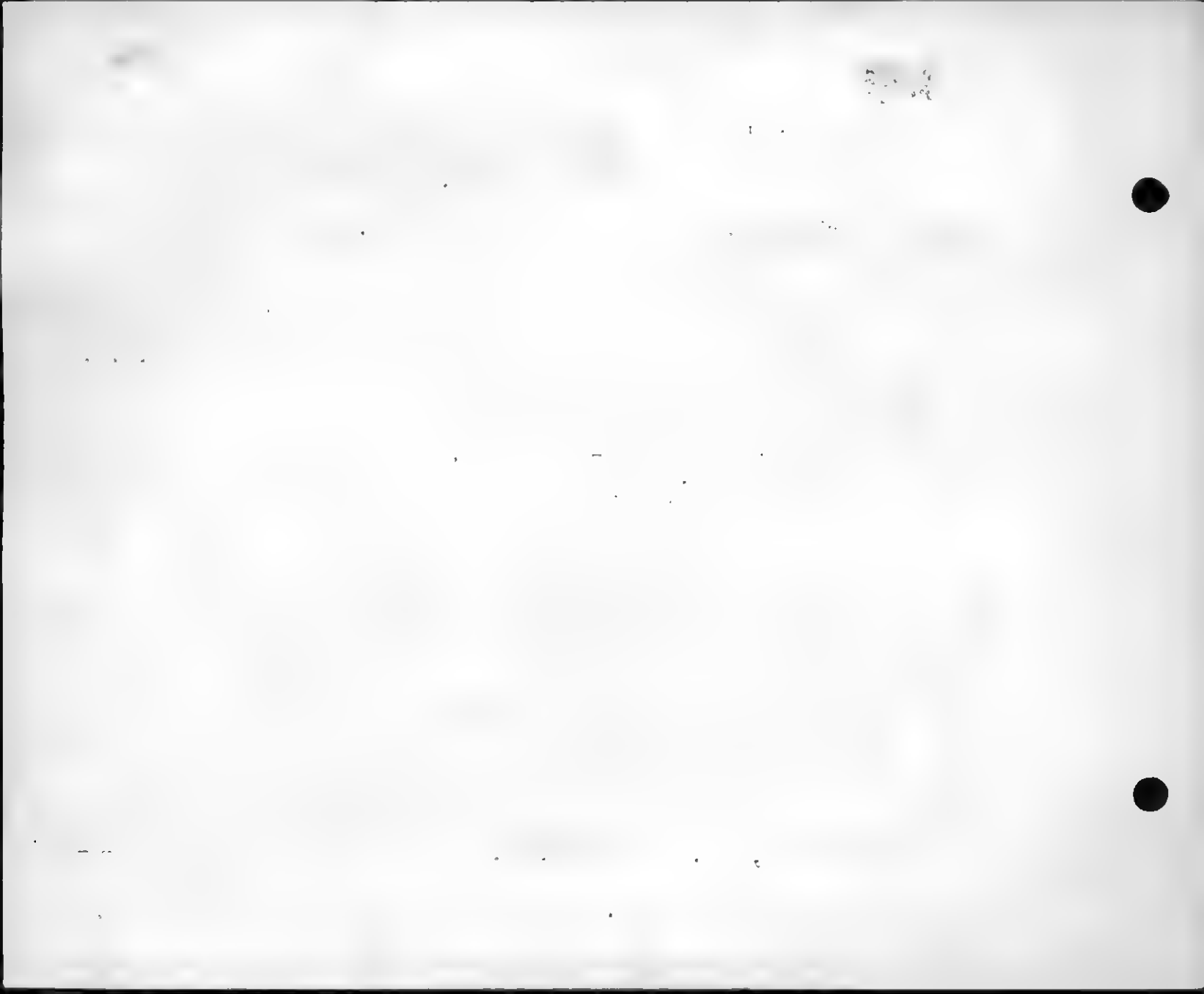
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04097

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04096

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY N 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		2 USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 4227 30th. Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Henry First Middle Last Lott		4 DATE OF DEATH Month Day Year 3 3 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1 March 1903 9 AGE (In years last birthday) 64 yrs
10a USUAL OCCUPATION (Give kind of work done during past 12 months, even if retired) Tailor-Fitter		10b KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop	11 BIRTHPLACE (State or foreign country) Frankfort, Germany 12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Hienrsch Lott		14. MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 577-01-3898	17. INFORMANT Mrs. Eva Lott (above address) Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 44-X DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 3-3-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 3/6/67	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d LOCATION (City or town) (County) (State) Colmar Manor, Md.
24 FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a REC'D BY REGISTRAR Maryland Rainier 25b REGISTRAR'S SIGNATURE Charles Judge DATE MAR 7 1967	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

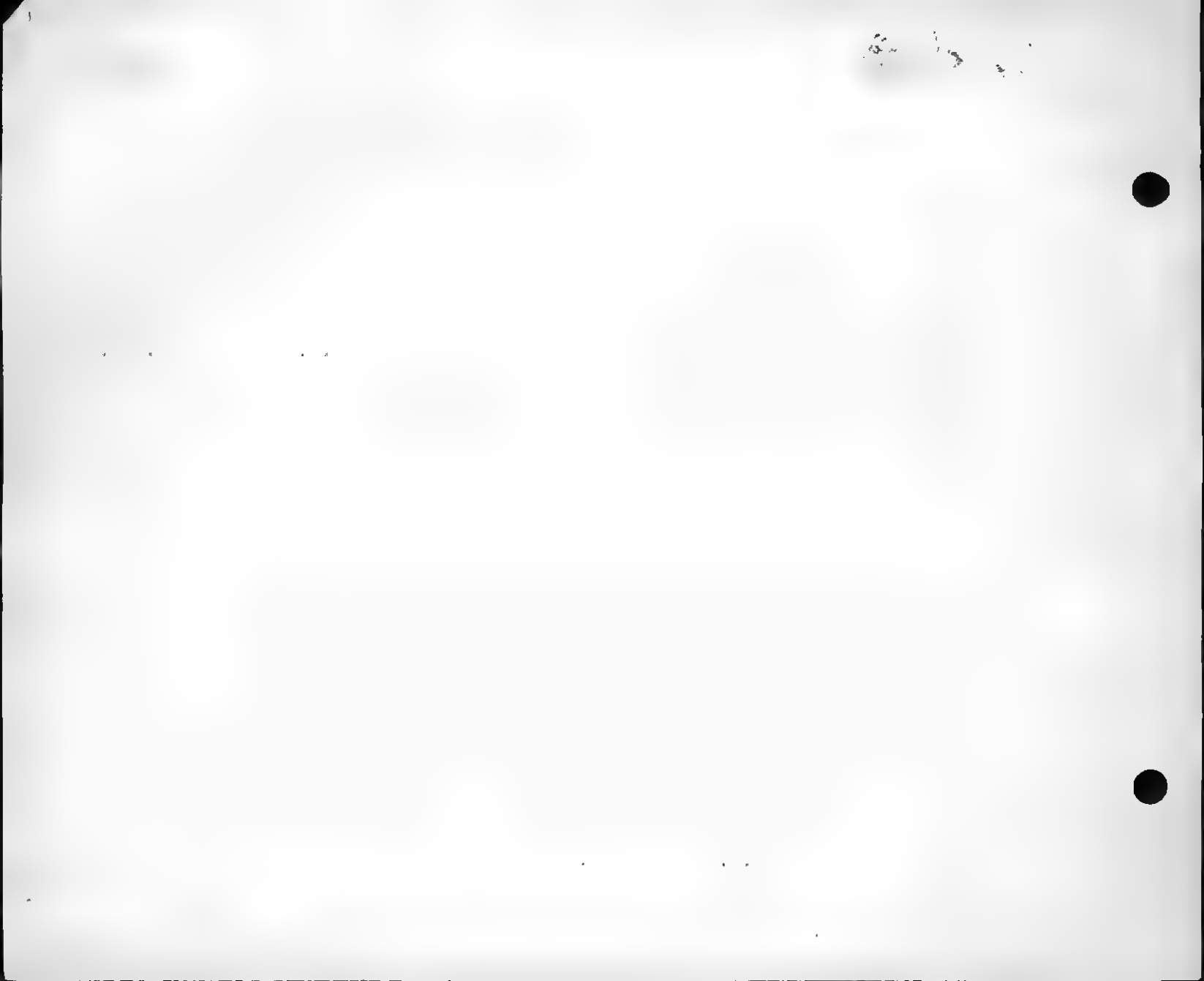
04098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 18 & 21, Film G 391 8-1/67 cag

04097

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution on Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital		d STREET ADDRESS 5420 55th Place	
3 NAME OF DECEASED (Type or print) First Middle Last Thomas Kevin Lynch		4 DATE OF DEATH Month Day Year 3 24 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-6-67
9 AGE (In years last birthday) yrs 18		IF UNDER 1 YEAR Months Days Hours Min 18	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b KIND OF BUSINESS OR INDUSTRY none	
11 BIRTHPLACE (State or foreign country) Washington D.C.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME William P. Lynch		14 MOTHER'S MAIDEN NAME Catherine Lacey	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give war or dates of service) no		16 SOCIAL SECURITY NO. none	
17 INFORMANT William P. Lynch Same as #2 (father)		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Undetermined DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) SDII DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22 DATE SIGNED 3-25-67	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3/27/67	
23c NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d LOCATION (City or Town) (County) (State) Silver Spring Montgomery Md.	
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md		25a REC'D BY REGISTRAR MAR 28 1967	
		25b REGISTRAR'S SIGNATURE J. Charles Judge	



04099

CERTIFICATE OF DEATH

04098

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>618 16th Street</u>		d. STREET ADDRESS <u>618 16th Street</u>	
3. NAME OF DECEASED (Type or print) <u>Grace Mack</u>		4. DATE OF DEATH <u>3</u> <u>24</u> <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1885</u>
9. AGE (In years last birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hollywood, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John S. Mack</u>		14. MOTHER'S MAIDEN NAME <u>Grace S. Mack</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-11-11-11-11</u>	
17. INFORMANT <u>John Mack</u>		Address <u>1111 Mack St. Laurel, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Same</u> DUE TO (c) <u>Arteriosclerosis (Cerebral)</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6</u> <u>1955</u> to <u>3-24</u> <u>1967</u> , that (I) (we) lost saw the deceased alive on <u>3-23</u> <u>1967</u> , and that death occurred at <u>2304</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edolo Pirandrea</u> M.D.		22b. DATE SIGNED <u>3-25-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel Md. Prince George's</u>
24. FUNERAL DIRECTOR <u>Robert L. ...</u>		25a. REC'D BY REGISTRAR <u>DATE 30 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

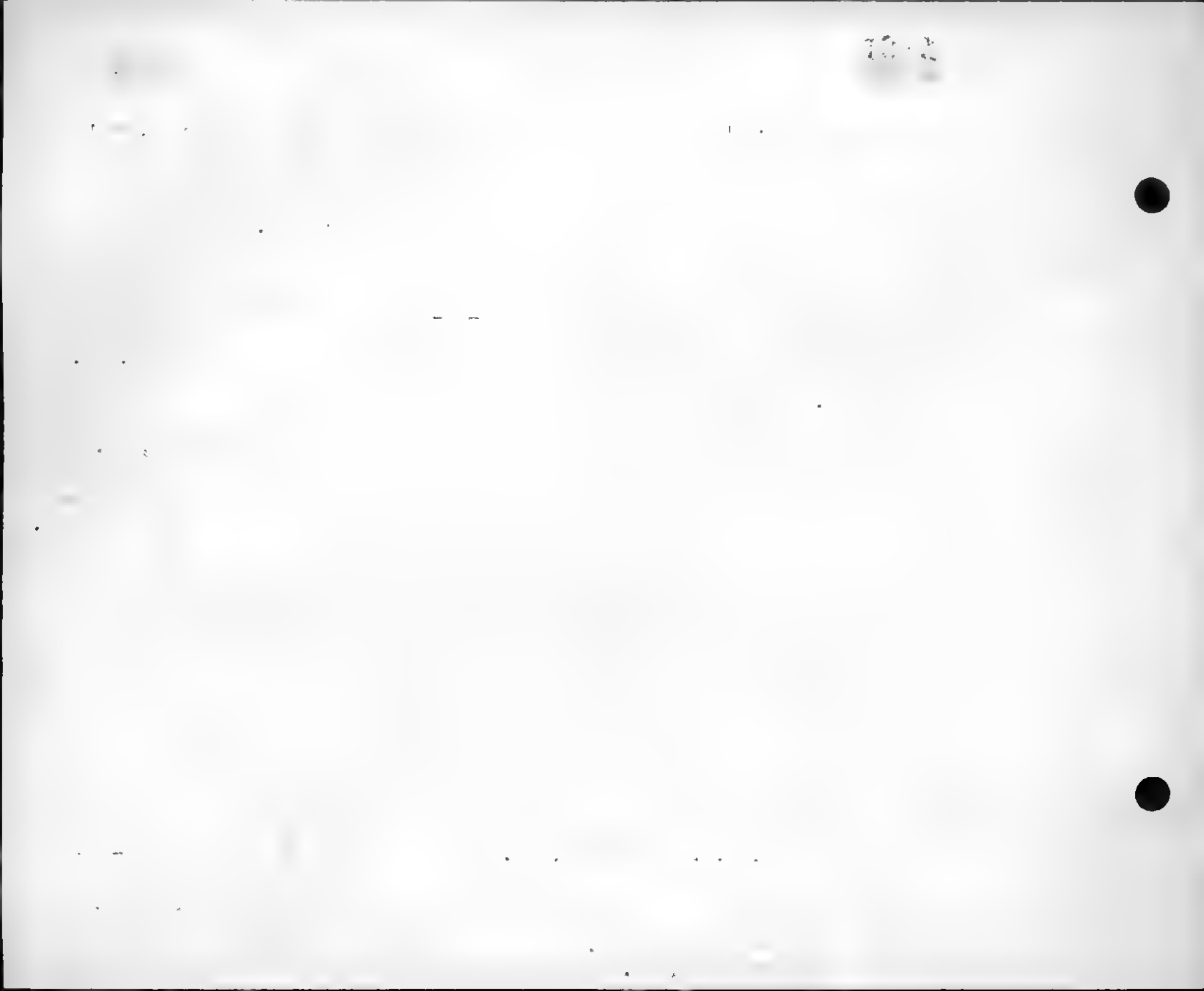
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04099

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c LENGTH OF STAY IN 1b DOA		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d STREET ADDRESS 8620 Baltimore Blvd.		
3 NAME OF DECEASED (Type or print) First Middle Last Alvin James Maggard			4 DATE OF DEATH Month Day Year 3 9 1967		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-22-1911	9 AGE (In years last birthday) 55	10 IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b KIND OF BUSINESS OR INDUSTRY Gas Station		11 BIRTHPLACE (State or foreign country) Virginia	
13 FATHER'S NAME JESSIE E. MAGGARD			14 MOTHER'S MAIDEN NAME ELLIE HARPER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) YES WWII		16 SOCIAL SECURITY NO		17. INFORMANT Name Address Roy A. Green Appalachia, Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)					INTERVAL BETWEEN ONSET AND DEATH minutes over 1 mo.
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town) (County) (State)		
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.			22 DATE SIGNED 3-10-67		
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			Address (Street, city, town, or county)		
23a BURIAL CREMATION REMOVAL (Specify) BURIAL	23b DATE THEREOF 3-13-67	23c NAME OF CEMETERY OR CREMATORY GLENCOE	23d LOCATION (City or town) (County) (State) BIG STONE GAP, VA.		
24 FUNERAL DIRECTOR GASCH'S ADDRESS 4739 Baltimore Ave. Hyattsville, Md.			25a REC'D BY REGISTRAR DATE MAR 13 1967	25b REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

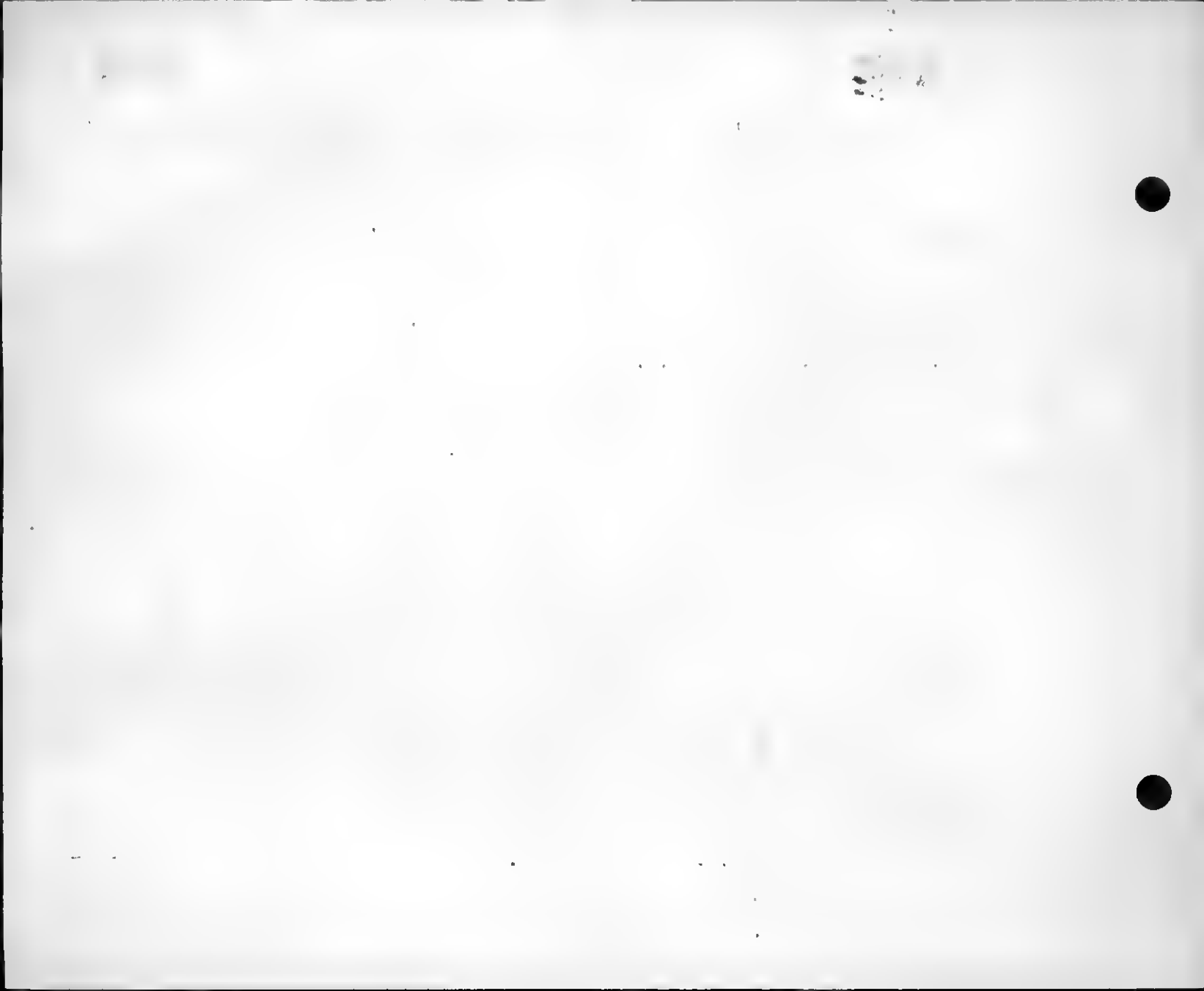
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Form #9-7-73/1-87 pc
04101 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **04100**

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 3426 79th. Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Francis Earl Manion				4. DATE OF DEATH Month Day Year 3 22 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Aug. 1901		9. AGE (In years last birthday) 65 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lt. Fire Dept.			10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Manion				14. MOTHER'S MAIDEN NAME Mary Vangueder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO		17. INFORMANT Olie G. Manion Same As # 2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH minutes over 1 year.
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 3-22-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/25/67		23c. NAME OF CEMETERY OR CREMATORY Wash. National Cemetery		23d. LOCATION (City or town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland Maryland				25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

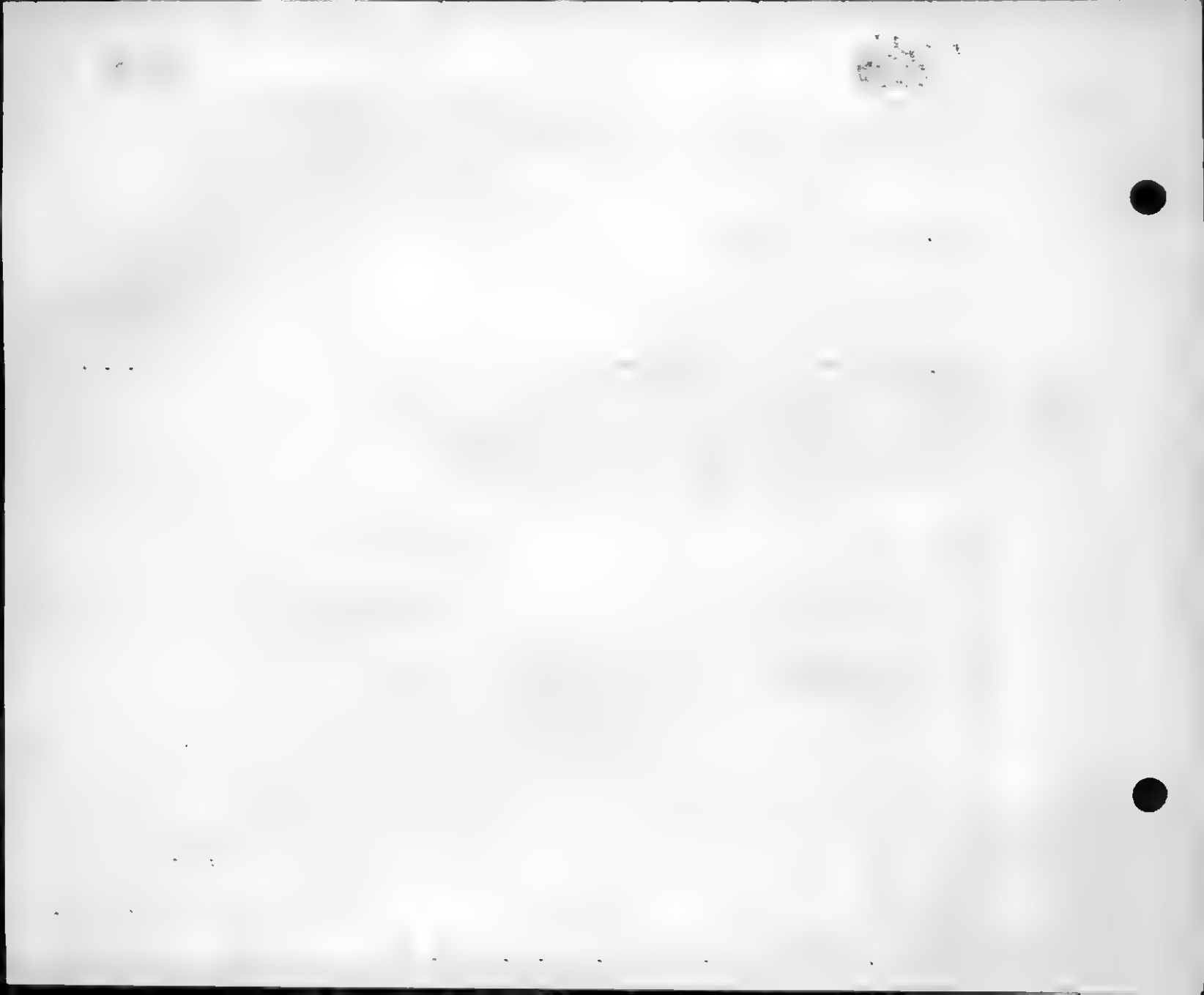
04102

CERTIFICATE OF DEATH

04101

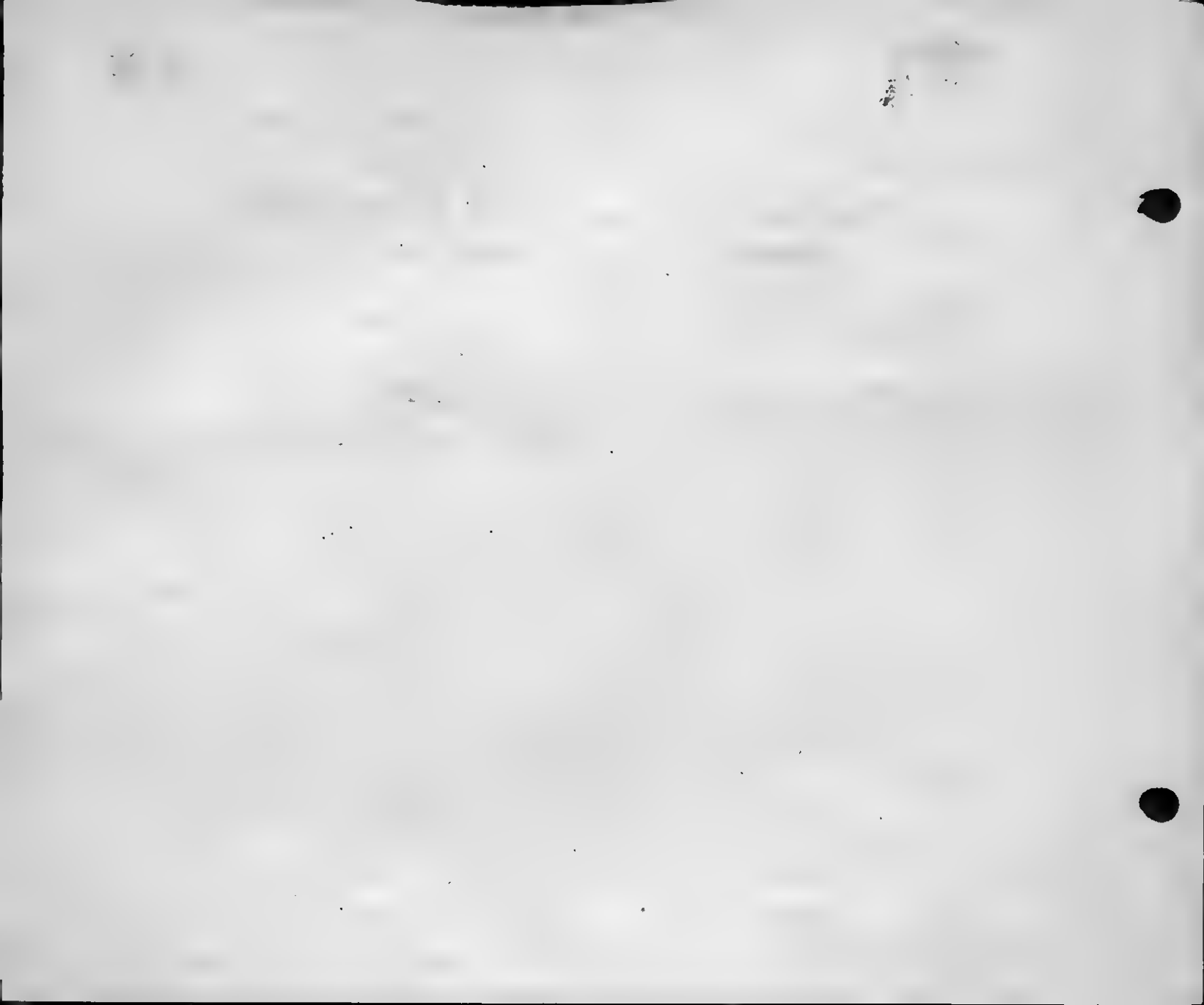
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Banham</u>		c. LENGTH OF STAY IN TB <u>8 mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u>		d. STREET ADDRESS <u>3905 Carwell Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Jack</u> First Middle Last <u>(NMD) Marcus</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Hotel worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotels</u>	9. AGE (In years last birthday) <u>75</u> yrs
11 BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>057-01-6438</u>	
17. INFORMANT <u>Joseph Marcus</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Occlusion</u> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>Mar 3</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>Mar 2</u> , 19 <u>67</u> , and that death occurred at <u>9:00</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Wm. H. Heco</u>		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Heco</u>		22d. ADDRESS <u>Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/6/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George County, Md.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc., 8434 Ga. Ave., S.S., Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MEDICAL CERTIFICATION

VR A15 (4
20M S-63



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

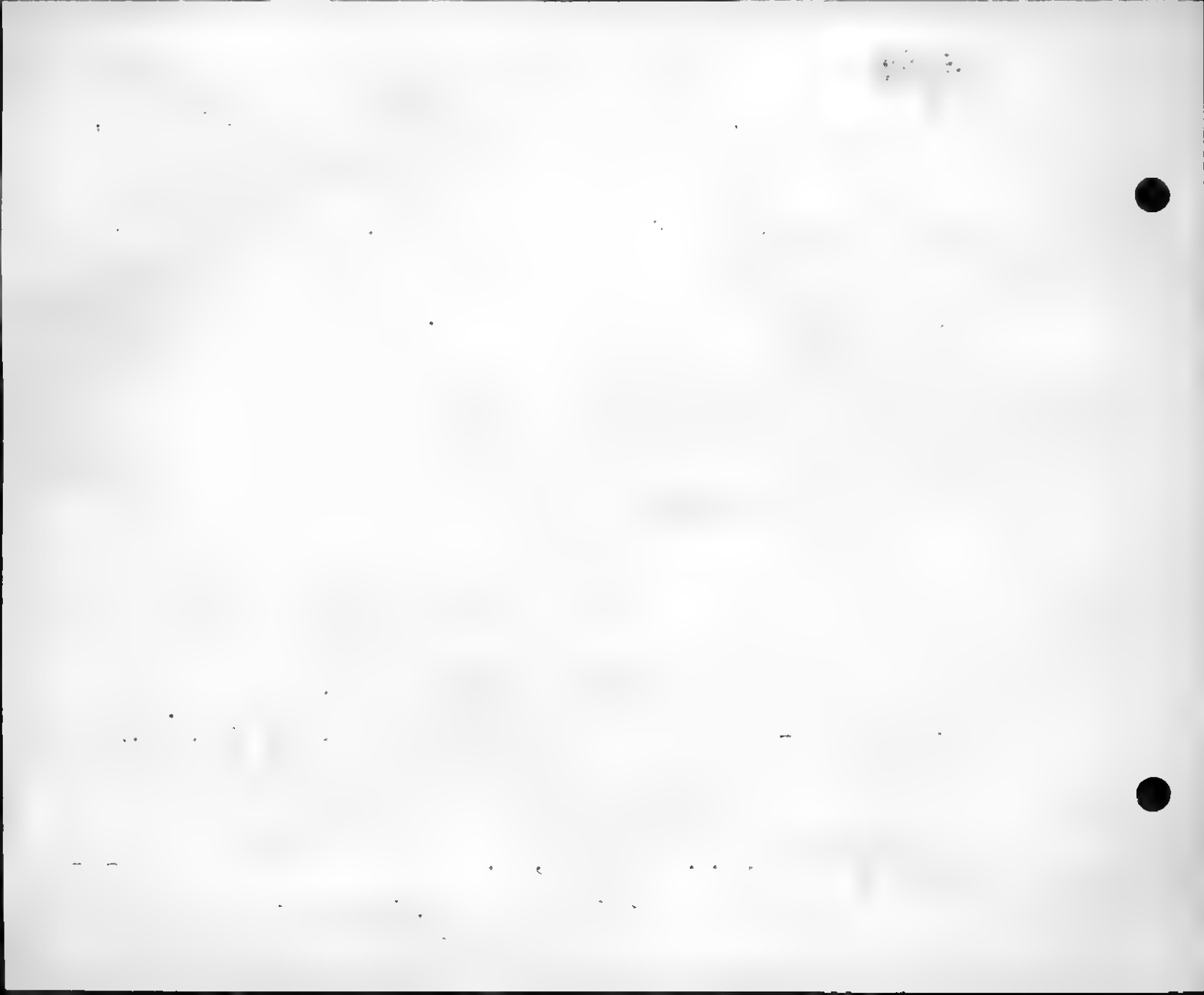
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04104

04103

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 1014 62nd. Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ronald			4. DATE OF DEATH Month 3 Day 14 Year 19 67		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Aug. 1956		9. AGE (In years last birthday) 10 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME ? Massey			14. MOTHER'S MAIDEN NAME Rosal Thomas		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rosal Massey Address 1014-62nd Pl.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2798 IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Drowned while swimming in creek.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 6:45pm 3-14- 19 67		20d. INJURY OCCURRED 2 While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cheverly, Md. (County) (State) Cabin Branch creek, near 62nd. Ave.,	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-15-67	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-18-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery Washington DC	
24. FUNERAL DIRECTOR H.S. Washington Sons		ADDRESS 4925 Penn Ave NE		25. REGISTRATION BY REGISTRAR 20 1967	
				26. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

04105

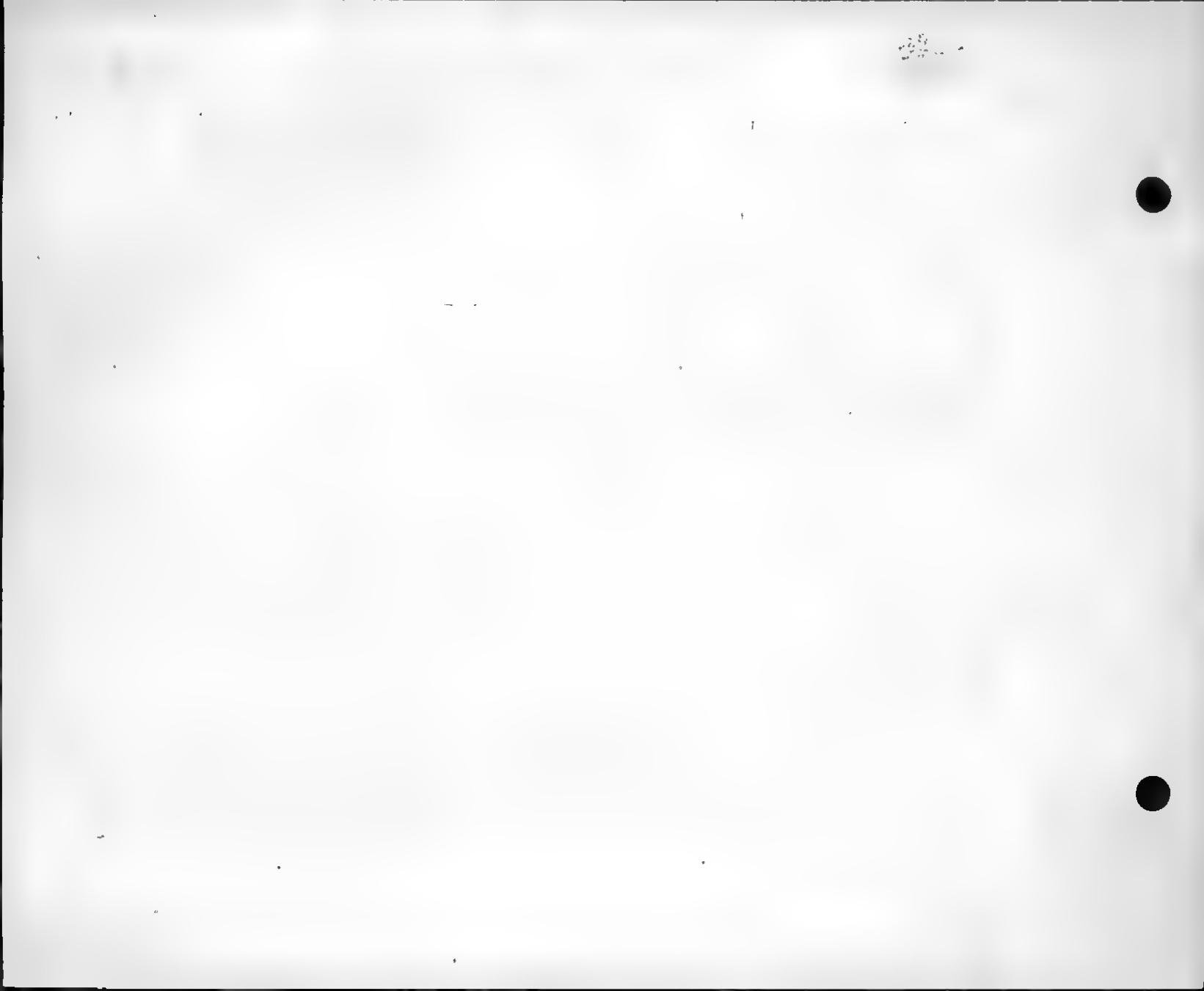
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04104

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		d STREET ADDRESS 4912 42nd Place	
3 NAME OF DECEASED (Type or print) Benjamin Archibald McClay		4 DATE OF DEATH Month Day Year March 11 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-1-92
9 AGE (In years birth day) yrs 74		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor	
10b KIND OF BUSINESS OR INDUSTRY U.S. Govern.		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Andrew E. McClay	
14. MOTHER'S MAIDEN NAME Unknown		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO 577-56-5124		17 INFORMANT Doris V. Whitney	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease (c) unknown		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-11-67	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 3-14-67	
23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION (City or town) (County) (State) Suitland, Md.	
24 FUNERAL DIRECTOR Lee Funeral Home		25 ADDRESS Washington, D.C.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04106

CERTIFICATE OF DEATH

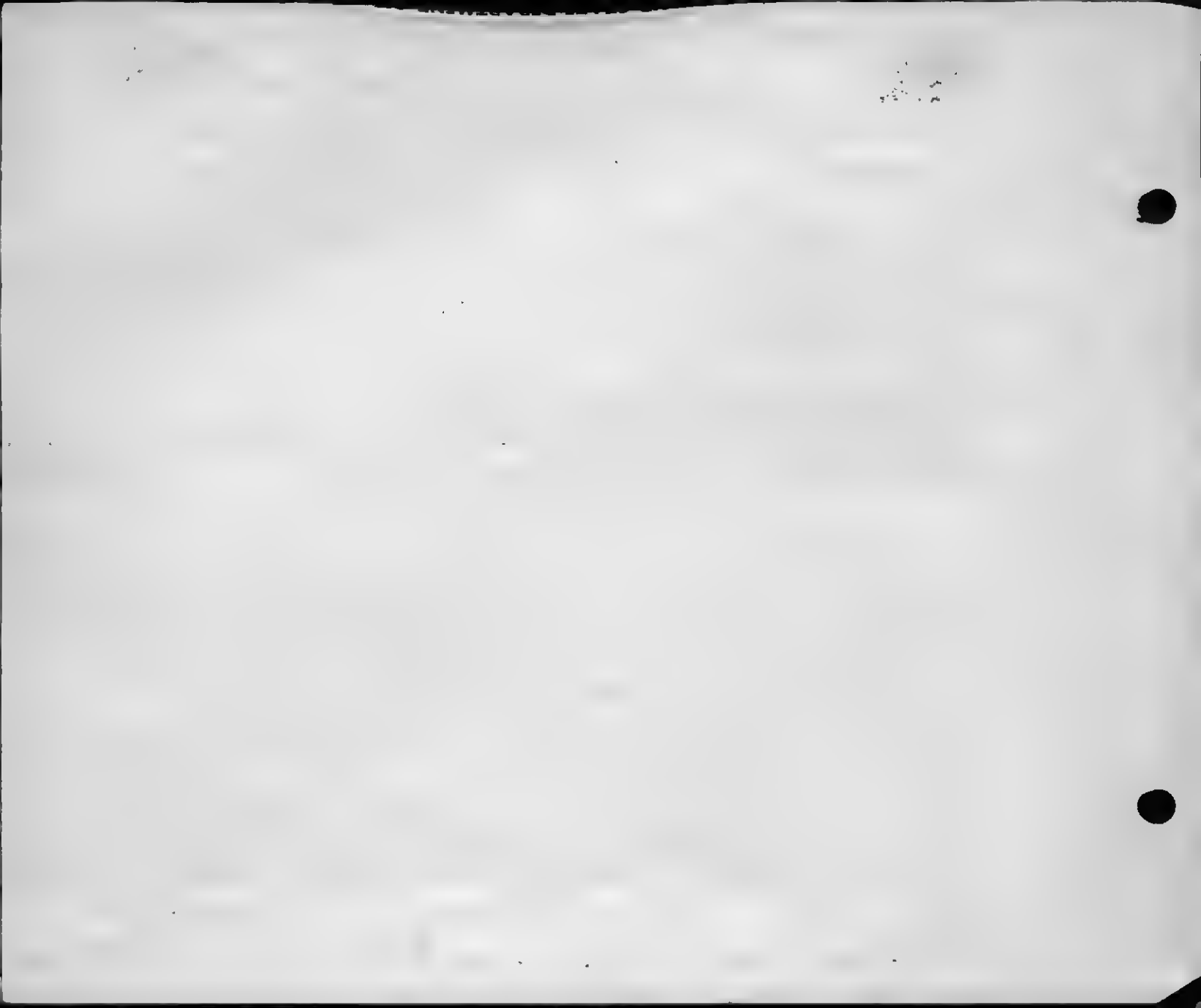
04107

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5418 Macbeth Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARGARET VICTORIA MCCLUNG</u>				4. DATE OF DEATH <u>March 31 1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 27 1884</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>Conrad Zink</u>				14. MOTHER'S MAIDEN NAME <u>Mary Weaver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Conrad D. McClung-son</u>				Address <u>Ellicott City Md.</u>			
18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u>							<u>5 yrs</u>
Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u>							
(a), stating the underlying cause last. (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 31 1967</u> to <u>date</u> 1967, that (I) (the) last saw the deceased alive on <u>Mar 31 1967</u> , and that death occurred <u>April 1 1967</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Warren B. Burch</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Mar 31, 1967</u>	
22c. PHYSICIAN'S NAME <u>WARREN B. BURCH</u>				22d. ADDRESS <u>405 A St S.E. Wash 3, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Memo. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Elkridge, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Fun. Home</u>				ADDRESS <u>300 4th St. N.E. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~return~~ give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04107

CERTIFICATE OF DEATH

04105 ✓

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Mason Beach Road	
3. NAME OF DECEASED (Type or print) First Iva Middle McDaniel Last McDaniel		4. DATE OF DEATH Month March Day 4 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/96
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME William C. Jones		14. MOTHER'S MAIDEN NAME Louette Marshall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 219-543474	
17. INFORMANT Ed. Brown		Address A.E. McDaniel, DENIC, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peripheral Circulatory Collapse DUE TO 1551 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Arteriosclerosis (c) Coronary of Left Bladder		INTERVAL BETWEEN ONSET AND DEATH 6 hrs unk unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May , 19 48 , to March 4 , 19 67 , that (I) (we) last saw the deceased alive on 4 Mar 19 67 , and that death occurred at 2:25 M, from causes and on the date stated above.			
22a. SIGNATURE R. B. Danner		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAR 7, 1967	
23c. NAME OF CEMETERY OR CREMATORY FRIENDSHIP		23d. LOCATION (City or Town) (County) (State) FRIENDSHIP, MD	
24. FUNERAL DIRECTOR T. H. Hensley		25a. REC'D BY REGISTRAR Mar 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04108

04106

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5610 - 54th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Cora A. McKinney				4. DATE OF DEATH Month Day Year March 1, 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/81		9. AGE (In years lost birthday) yrs 86	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilmer Rowe				14. MOTHER'S MAIDEN NAME Amanda Carter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578 03 3273		17. INFORMANT Marie M Russell Address Riverdale, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1966</u> to <u>March 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 1, 1967</u> , and that death occurred at <u>9:50 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <i>Thomas G. Maloney</i> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Mar 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M.D.				22d. ADDRESS 4714-71st Ave. Landover Hills, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 4, 1967		23c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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27

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04109

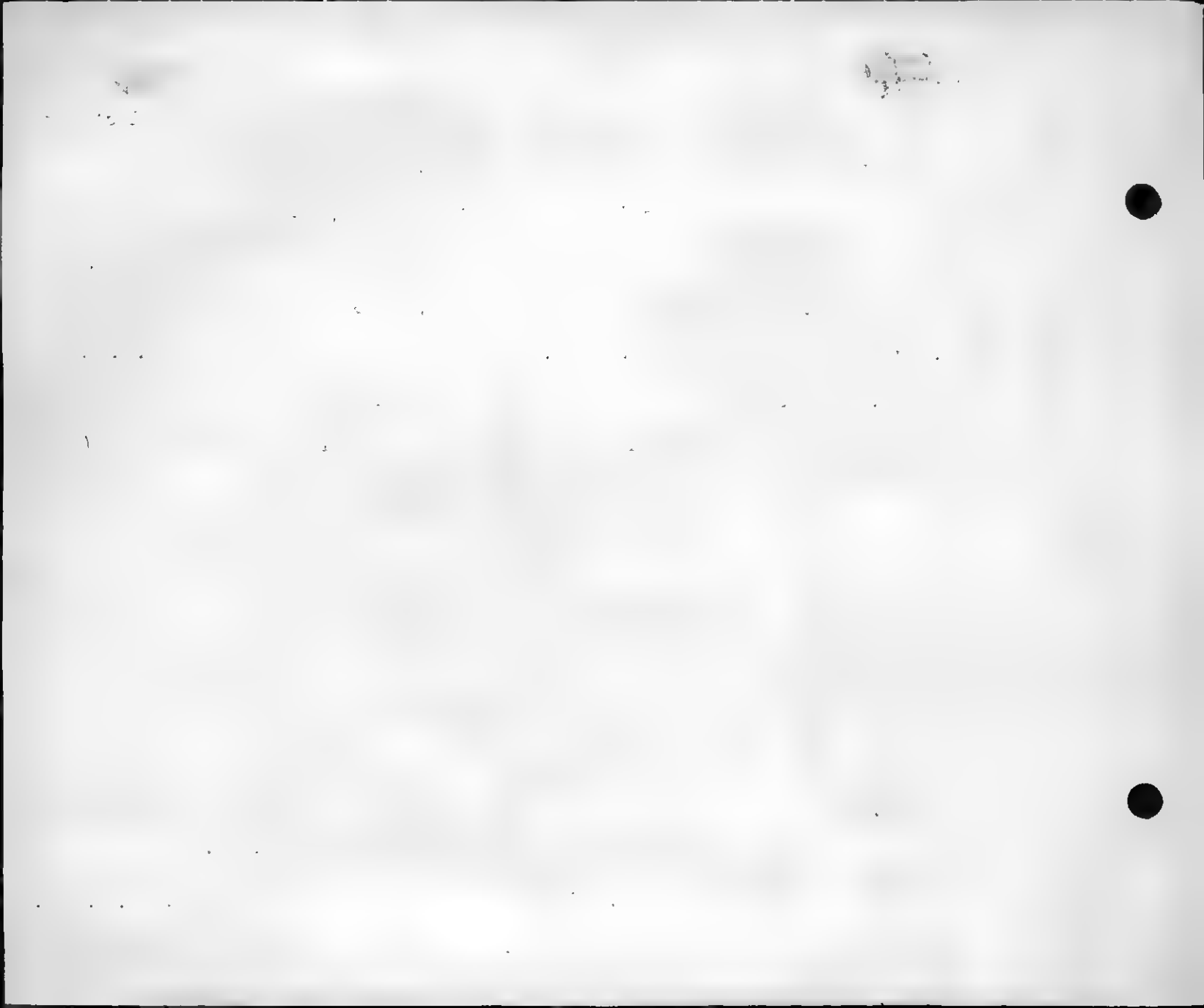
CERTIFICATE OF DEATH

04108

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 3700 Tilden Street	
3 NAME OF DECEASED (Type or print) George D McMichael		4 DATE OF DEATH Month March Day 23 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 3, 1883
9 AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Owner		10b. KIND OF BUSINESS OR INDUSTRY Transit Co.	
11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John V. McMichael		14. MOTHER'S MAIDEN NAME Elizabeth Cheek	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578 48 5516	
17. INFORMANT George W. McMichael		Address Same as #2 (son)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Pancytopenia DUE TO (c) Lymphosarcoma		INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 weeks 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (1) (this hospital) attended the deceased from 19 47 to March 19 67 , that (2) (we) saw the deceased alive on MARCH 22 19 67 , and that death occurred at 2:10 AM , from causes and on the date stated above.			
22a. SIGNATURE Benjamin S. Miller		22b. DATE SIGNED March 23 67	
22c. PHYSICIAN'S NAME (Type) Benjamin S Miller		22d. ADDRESS Mt Rainier, Md.	
23a. BURIAL CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 3/25/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor, P.G. M.d	
24. FUNERAL DIRECTOR Francis Gasch's Sons		25a. REC'D BY REGISTRAR MAR 27 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04110		04109	
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORRESTVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest HEIGHTS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Regent Nursing & Rehabilitative Centre</u>		e. STREET ADDRESS <u>5004 DIXON ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>HELEN</u> Middle <u>S.</u> Last <u>MERRICK</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH SPIESMAN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE KNEIB</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>208-14-0455</u>	
17. INFORMANT Address <u>MRS ED. J. KANE GOSHEN RD. NEWTOWN SQUARE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>1201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>acute coronary occlusion.</u> DUE TO (c) <u>arteriosclerotic heart disease.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.V.A. 2 left hemiparesis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) just saw the deceased alive on _____, 19____, and that death occurred at <u>5:45 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Kelvin L. Minchin</u> M.D.		22b. DATE SIGNED <u>3/24/67</u>	22c. PHYSICIAN'S NAME (Type) <u>KELVIN L. MINCHIN</u>
22d. ADDRESS <u>6600 MARLBORO PIKE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-29-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST DENIS</u>	23d. LOCATION (City or town) (County) (State) <u>HAVERTOWN DELAWARE - PA.</u>
24. FUNERAL DIRECTOR <u>Robert T. Roche</u>		ADDRESS <u>5350 CEDAR AVE PHILA. PA</u>	25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

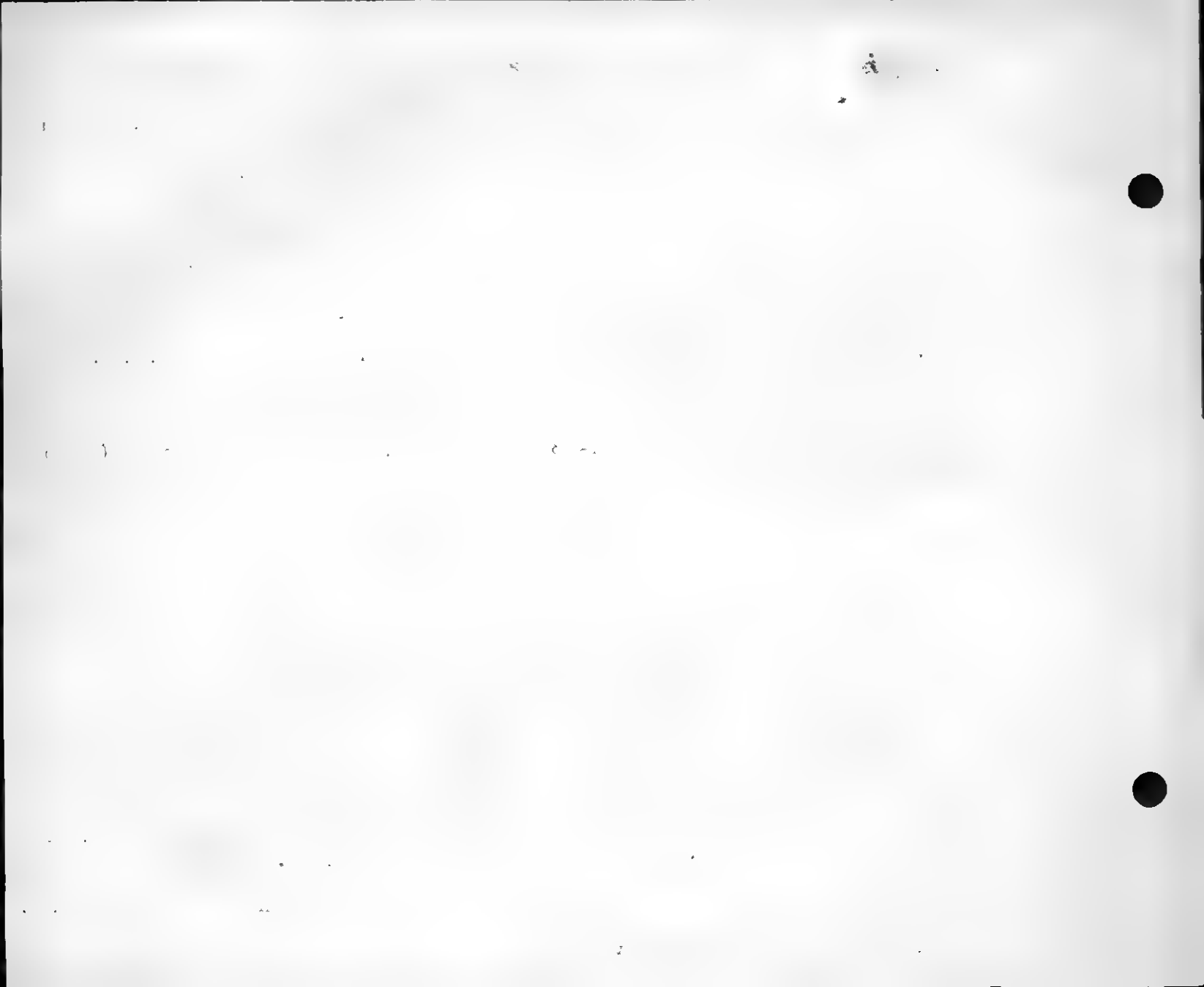
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04111

04110

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital				d. STREET ADDRESS 1934 Yates Avenue			
3 NAME OF DECEASED (Type or print) First Middle Last Joseph NMI Mischel				4 DATE OF DEATH Month Day Year March 10 1967			
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 19, 1900		9 AGE (in years last birthday) 66 yrs	10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ret. Painter			10b KIND OF BUSINESS OR INDUSTRY Homes		11 BIRTHPLACE (State or foreign country) Hungary		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME Matthew Mischel				14 MOTHER'S MAIDEN NAME Katherine Scheurich			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOC. SEC. NO. 115 12 4993		17 INFORMANT Address Florence L. Mischel Same as #2 (wife)			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) over 13 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Riverdale, Md.			
22. DATE SIGNED 3-11-67							
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3/14/67		23c NAME OF CEMETERY OR CREMATORY Woodlawn		23d LOCATION (City or town, County) (State) Bronx N. Y.	
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				REGISTERED 4 1967 DATE Mar 14 1967 REGISTRAR'S SIGNATURE John A. Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #0357 3/27/67 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

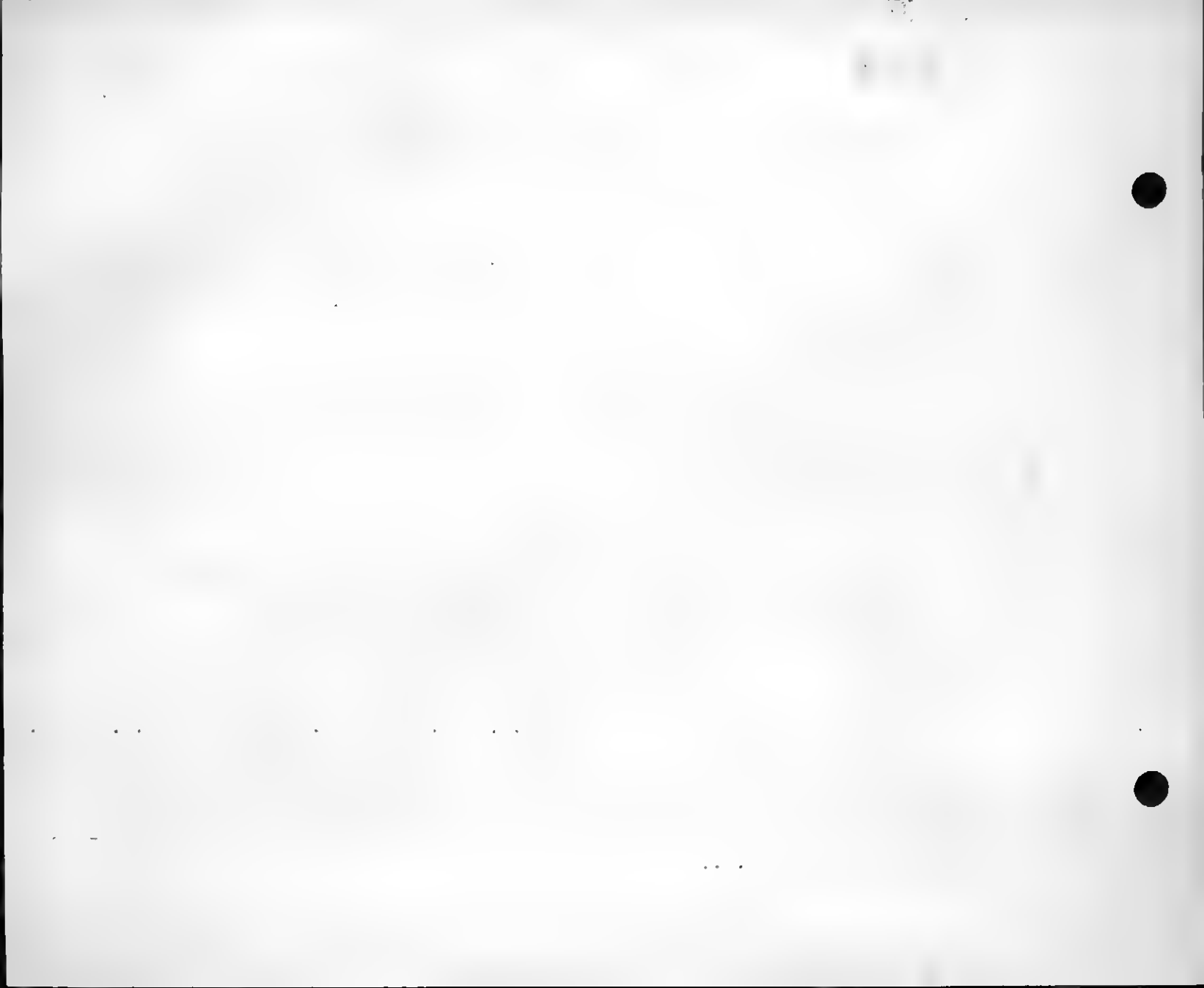
04112

04111

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a STATE Maryland b. COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY in 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d STREET ADDRESS 5210 Alton Street	
3 NAME OF DECEASED (Type or print) First Middle Last Joseph Walter Misiewicz		4 DATE OF DEATH Month Day Year 3 11 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH Nov 1941
9 AGE (In years lost birthday) 45 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Penn.	
12 CITIZEN OF WHAT COUNTRY?		13 FATHER'S NAME Walter Misiewicz	
14 MOTHER'S MAIDEN NAME Helen Gayda		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO 189-14-5493		17 INFORMANT Walter Misiewicz Int. Present Pa	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Bilateral Hemothorax DUE TO (c) Multiple Rib fractures (Trauma - auto accident)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) passenger in car involved in collision	
20c TIME OF INJURY Month, Day, Year Hour am pm 11:50pm 3-10 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work U.S. Rte. 1 at Rte. 193	
20e PLACE OF INJURY (Home farm factory street, office bldg, etc.)		20f (City or town) (County) (State) P.G. Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kenoe M.D.		22. DATE SIGNED 3-11-67	
EXAMINER'S NAME (Type) John Kenoe M.D., Riverdale, Maryland		23a CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		23b ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		23c DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street city, town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) 3-14-1967 Transfiguration Cemetery		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION City or Town (County) (State) East Huntingdon Twp. Chester Pa	
24 FUNERAL DIRECTOR Michael P. Geline 204 E. 1st St. Int. Present Pa.		25a REC'D BY REGISTRAR MAR 17 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

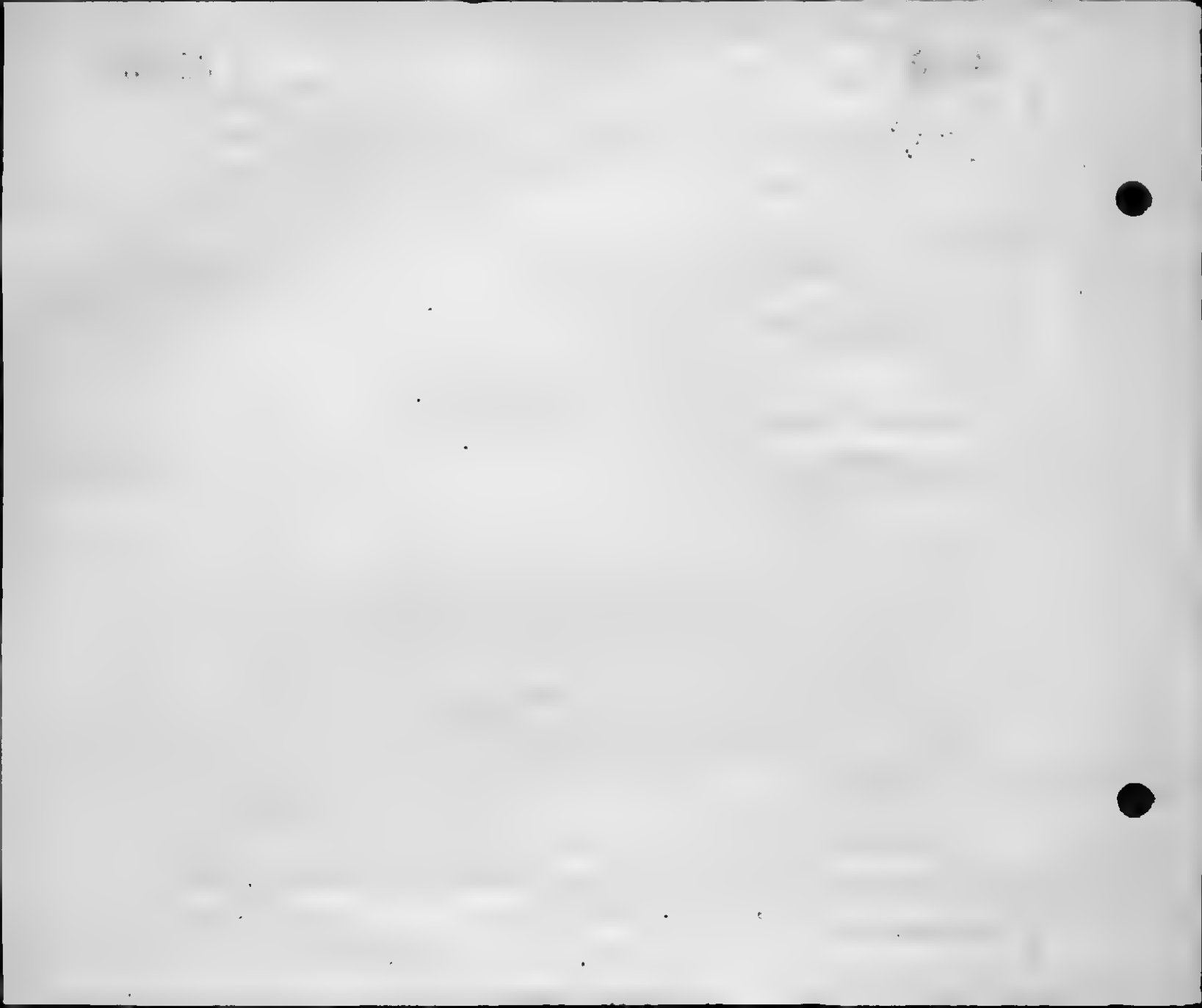


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 5 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04113						04112					
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY PRINCE GEORGES					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILCREST HEIGHTS						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILCREST HEIGHTS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5517 24th AVENUE						d. STREET ADDRESS 5517 24th AVENUE					
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE SCULLIN MORGAN						4. DATE OF DEATH Month Day Year MARCH 7 19 67					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH APRIL 16, 1900		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SCHOOL TEACHER				10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN ROBERT SCULLIN						14. MOTHER'S MAIDEN NAME CLARA R. PICKENS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT CHARLES R. SCULLINS Address SAME AS # 2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of the liver 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Adenocarcinoma of the colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1538										INTERVAL BETWEEN ONSET AND DEATH 6 mon. 1 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Mar 1 1967 to Mar 7 1967 , that (I) (we) last saw the deceased alive on Mar 1 1967 , and that death occurred at 3:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE Charles J. Talbot M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/7/67			
22c. PHYSICIAN'S NAME (Type) Frank J. Talbot MD						22d. ADDRESS 4273 Branch Ave Marlow Heights Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF March 11, 1967		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY				23d. LOCATION (City, town or county) (State) PARKERSBURG, WEST VIRGINIA			
24. FUNERAL DIRECTOR'S SIGNATURE WILHELM FUNERAL HOME 4308 SUITLAND RD. MARYLAND						ADDRESS SUITLAND		25a. REC'D BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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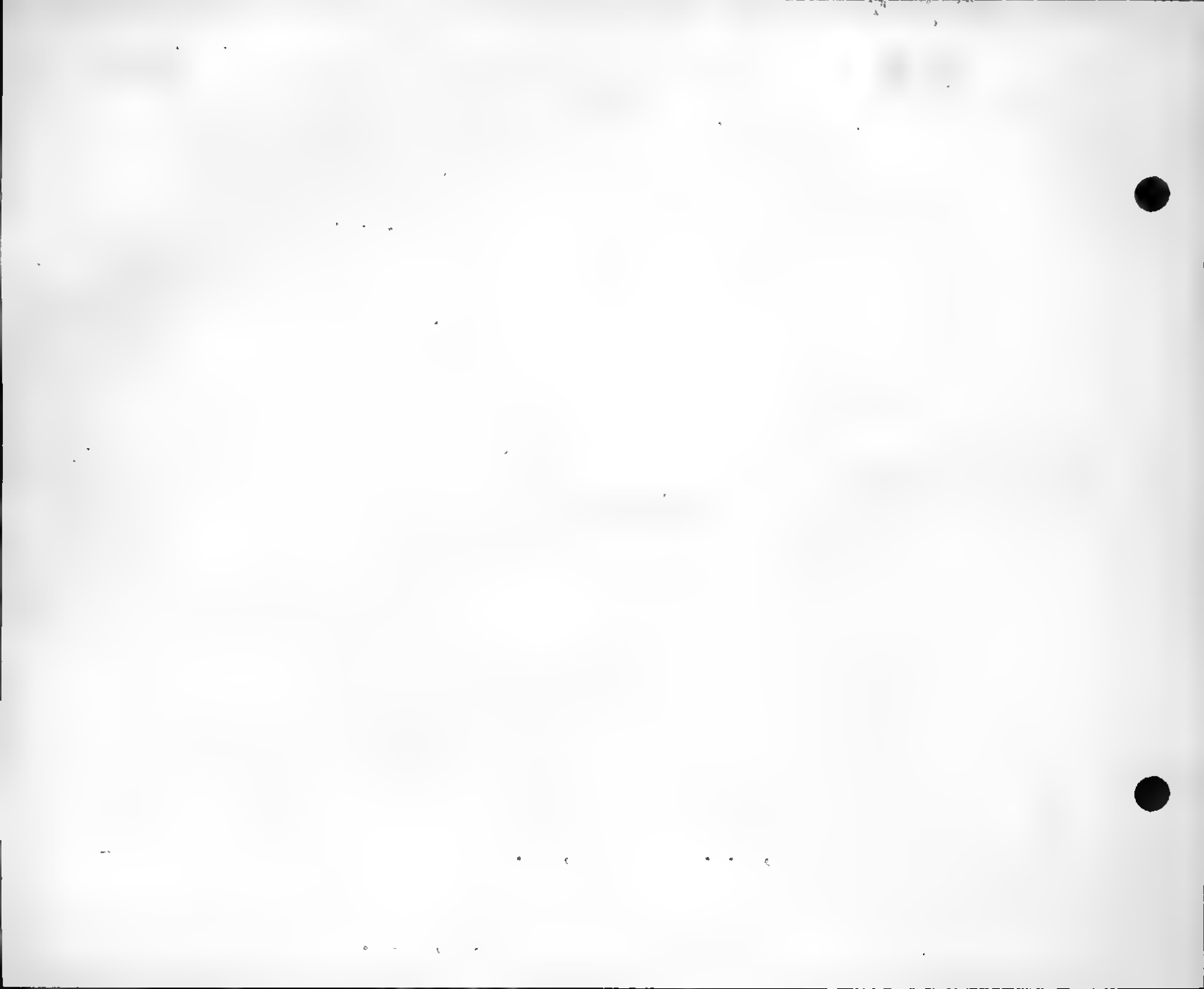
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04114

04113

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harwood	
c. LENGTH OF STAY In DOA		d. STREET ADDRESS Box 25A, Sands Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Helen T Myles		4. DATE OF DEATH Month Day Year 3 26 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 Nov. 1906
9. AGE (In years lost birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David Simms		14. MOTHER'S MAIDEN NAME Helen Diggs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John E. Myles-son		Address -4624 Blagden Terrace	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Not from causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 3-27-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/31/67	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park	23d. LOCATION (City or Town) (County) (State) Maryland
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd.,		25a. REC'D BY REGISTRAR N. MAR 29 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04115

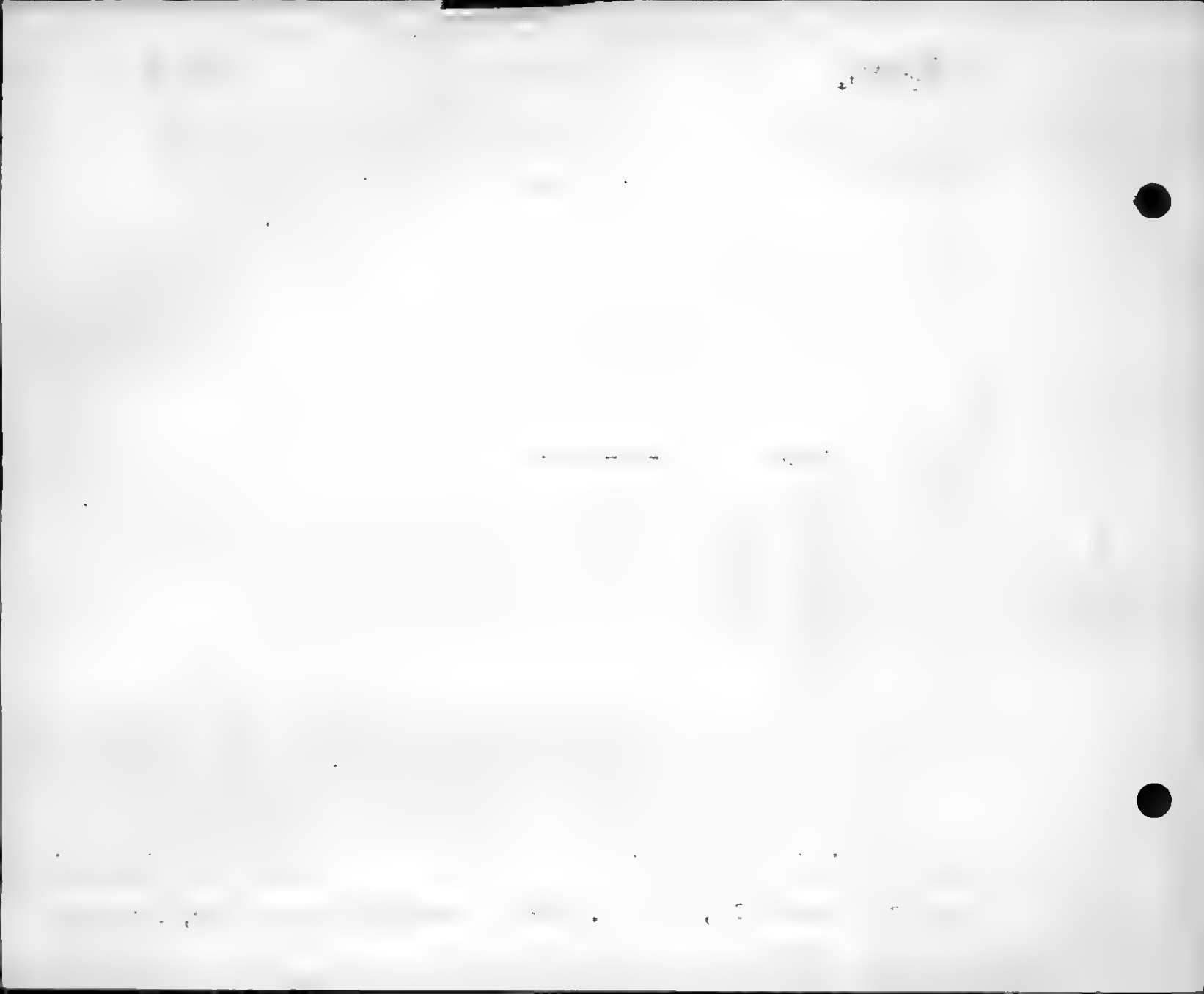
CERTIFICATE OF DEATH

04114

1 PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN TB 48 Years		2 USUAL RESIDENCE (Where deceased lived, if institution a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill		d. STREET ADDRESS 2517 Corning Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Mary Melissa Nimmo						4. DATE OF DEATH Month Day Year 3 9 19 67					
5 SEX female		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-25-01		9 AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11 BIRTHPLACE (County & State, or foreign country) Virginia				12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Osborn, Lloyd						14. MOTHER'S MAIDEN NAME Bowman, Cornelia					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None		16. SOCIAL SECURITY NO. 578-20-1110-B		17. INFORMANT Daughter & Medical Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 1231 IMMEDIATE CAUSE (a) DUE TO CEREBRAL EMBOLISM (b) ATRIAL FIBRILLATION (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH 12 DAYS 4 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from JULY, 1962, to 3-9-67, 19, that (I) (we) last saw the deceased alive on 3-9-67 19, and that death occurred at 2:25 P.M., from causes and on the date stated above.											
22a. SIGNATURE C. J. Houmann						M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 3-9-67			
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.						22d. ADDRESS 4404 Queen bury Rd., Riverdale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg Maryland			
24. FUNERAL DIRECTOR W. W. Chambers						25a. RECEIVED BY REGISTRAR MAR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

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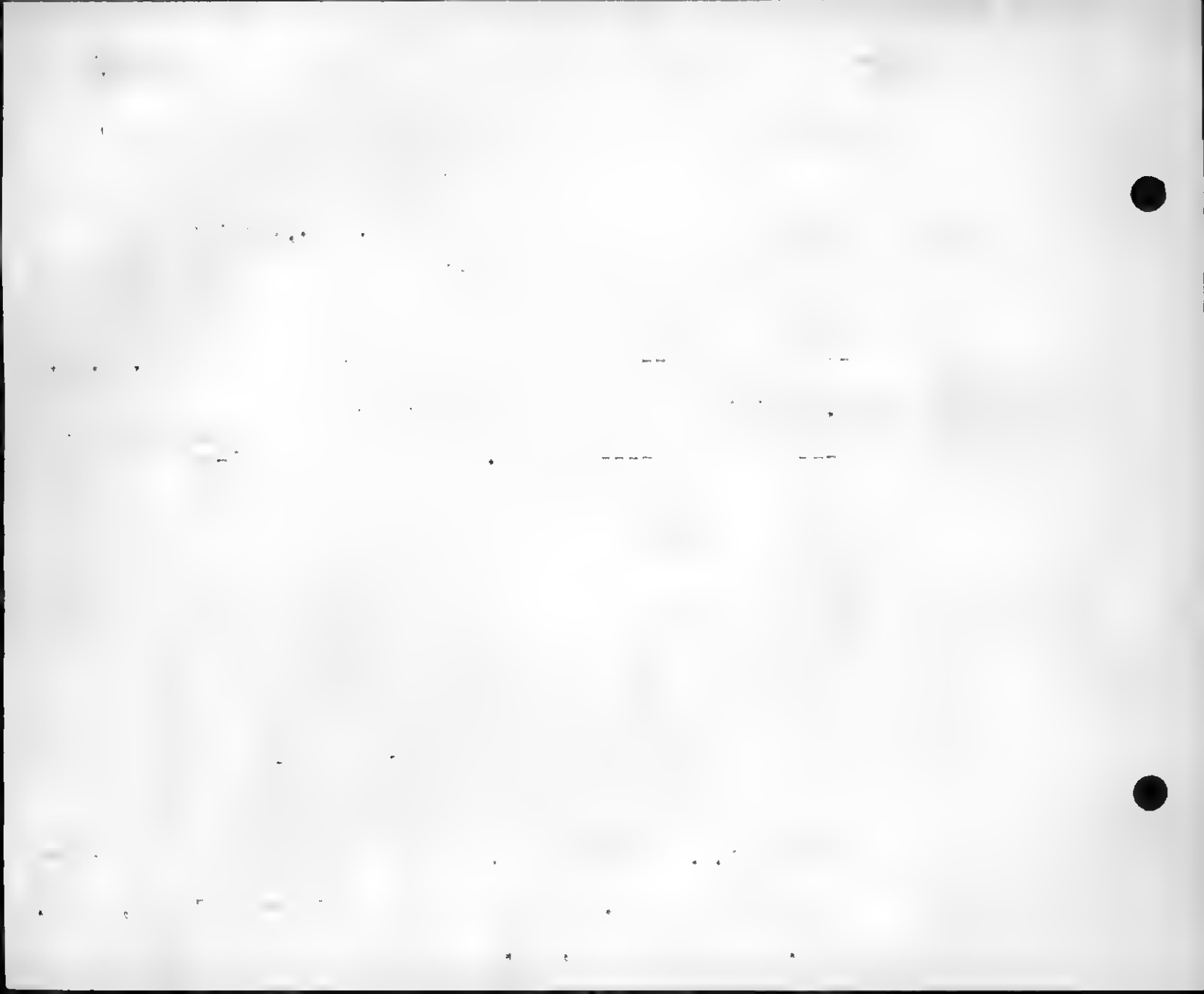
VR A15ME (5)
6M 1/67

05680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05680

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland	
c. LENGTH OF STAY IN TB DOA		d. STREET ADDRESS 7831 Penna. Ave., Apt 202	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last John Christopher Orsini		4 DATE OF DEATH Month Day Year 3 23 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11 April 1966
9 AGE (In years last birthday) yrs 11		IF UNDER 1 YEAR Months Days Hours Min 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Robert F. Orsini		14 MOTHER'S MAIDEN NAME Mary Smith	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO ----	
17 INFORMANT Mrs. Mary Smith Orsini-#2		Address Same as Item	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 762.0 IMMEDIATE CAUSE (a) Undetermined DUE TO SDII Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Associated with pulmonary congestion, bilateral DUE TO Pulmonary atelectasis, Focal (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-23-67	
23a. BIRTHPLACE (State or foreign country) Burial		23b. DATE THEREOF 3/27/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City or town) (County) (State) Upper Marlboro, Md.	
24 FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR APR 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

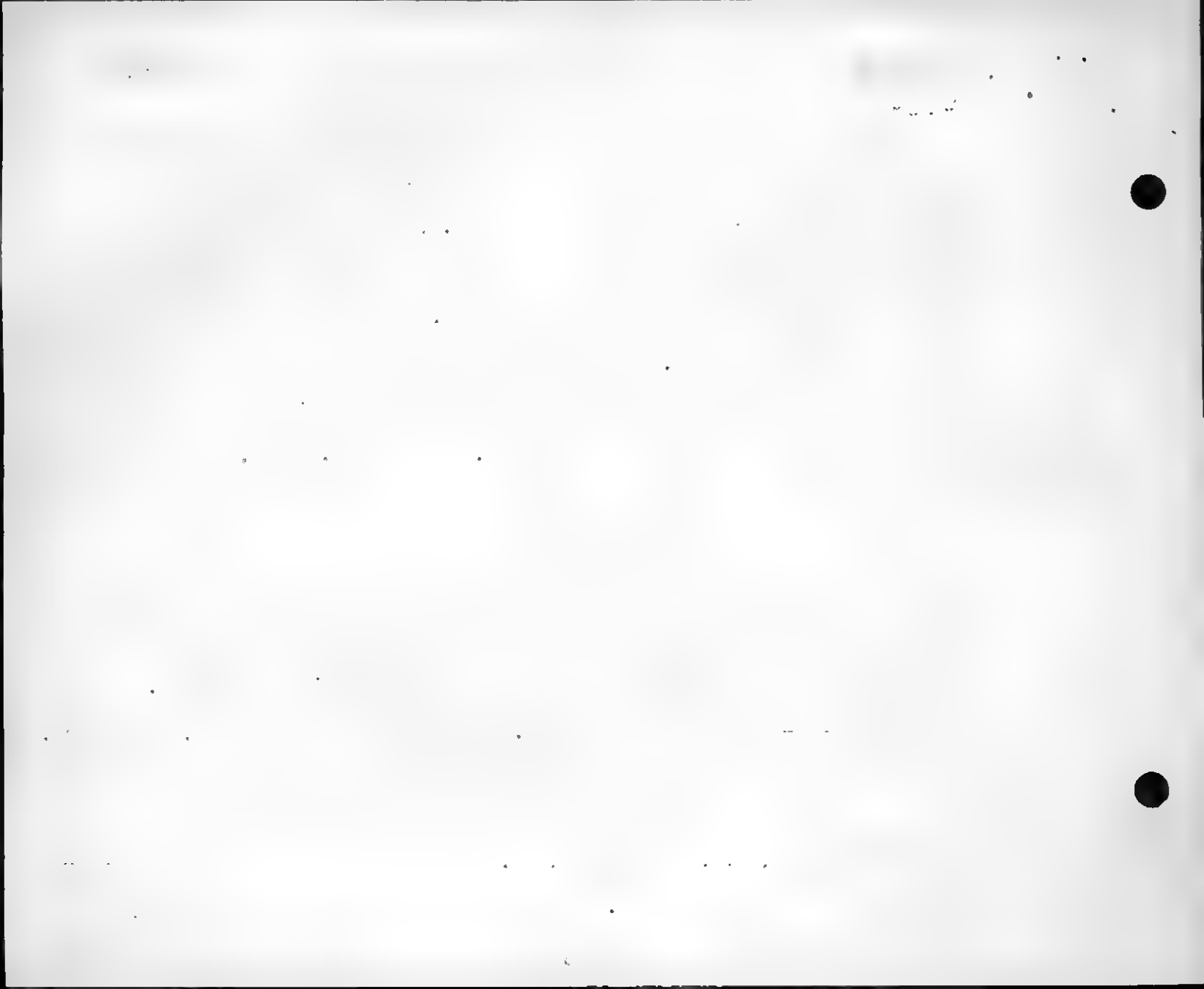
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04116

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04115

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS Rt. 1, Box 133		
3 NAME OF DECEASED (Type or print) First Middle Last William Lee Paddy			4 DATE OF DEATH Month Day Year 3 13 19 67		
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4 Oct. 1937	9 AGE (in years lost birthday) 29 yrs	10 F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator - Heavy Equip. Construction			11 BIRTHPLACE (State or foreign country) Annapolis, Maryland		
10b KIND OF BUSINESS OR INDUSTRY			12 CITIZEN OF WHAT COUNTRY? USA		
13 FATHER'S NAME Russell			14 MOTHER'S MAIDEN NAME Gladys Kirby		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16 SOCIAL SECURITY NO		
17 INFORMANT Address Mrs. Katherine Z. Paddy, same as 2					
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 1194 IMMEDIATE CAUSE (a) Laceration of brain DUE TO Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Passenger in car which struck bridge abutment.		
20c TIME OF INJURY Month, Day Year Hour a.m. 12:51am 3-13- 19 67			20d INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Rt. 450 at Whitfield Chapel Rd. Prince Geo. Co.		
20f (City or town) (County) (State)					
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.			22. DATE SIGNED 3-13-67		
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.			Address (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 16 March 67	23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d LOCATION (City or town) (County) (State) Baltimore, Maryland		
24 FUNERAL DIRECTOR ADDRESS Kirkley Funeral Home, Glen Burnie, Md.			25a REC'D BY REGISTRAR DATE MAR 16 1967 25b REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

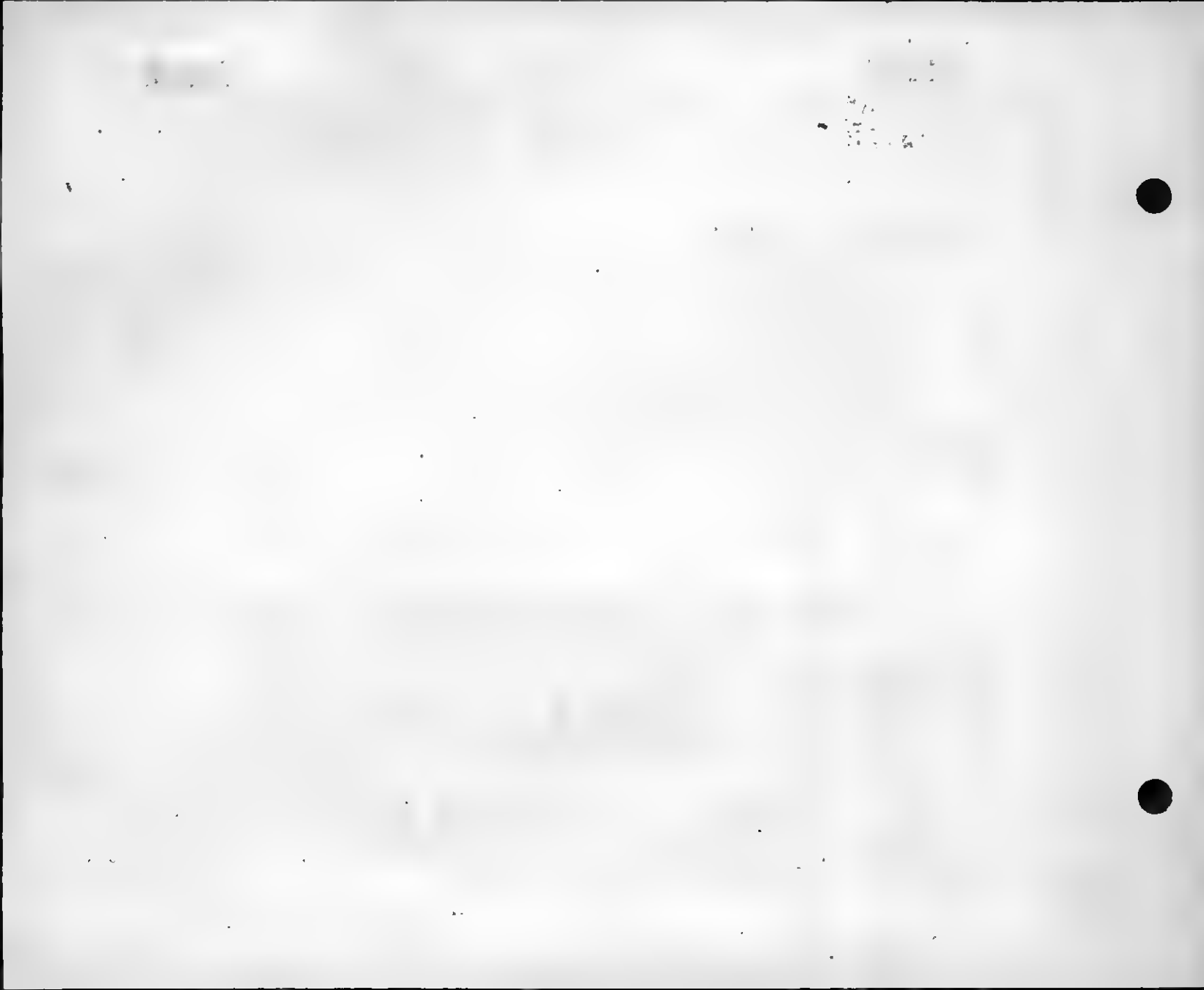
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04117

CERTIFICATE OF DEATH

04118

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308--Huron Dr., S. E.				d. STREET ADDRESS 308--Huron Dr., SE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Gladys Middle K. Last Page				4. DATE OF DEATH Month March Day 11th Year 19 67			
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 10-1900		9. AGE (In years last birthday) 66 yrs		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob XXXXXX Wooge				14. MOTHER'S MAIDEN NAME Carrie Johnson			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Colleen P. Mader Same as Item #2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Diabetes mellitus & hypertension</u> DUE TO (c) <u>obesity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 sudden</u> <u>6 years</u> <u>active life</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21 I certify that (I) (this hospital) attended the deceased from <u>11/2/1964</u> , 19__, to <u>3/11/1967</u> , 19__, that (I) (we) last saw the deceased alive on <u>3/11/1967</u> , 19__, and that death occurred at <u>NA</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Etienne Szollosi</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-11-1967</u>	
22c. PHYSICIAN'S NAME (Type) Dr. Etienne Szollosi				22d. ADDRESS <u>#2 Parkway Dr., SE Forest Hgts., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>	
24 FUNERAL DIRECTOR <u>Simmons Bros.</u>				25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
26 ADDRESS <u>Simmons Bros.-1661-Good Hope Rd SE Wash DC</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

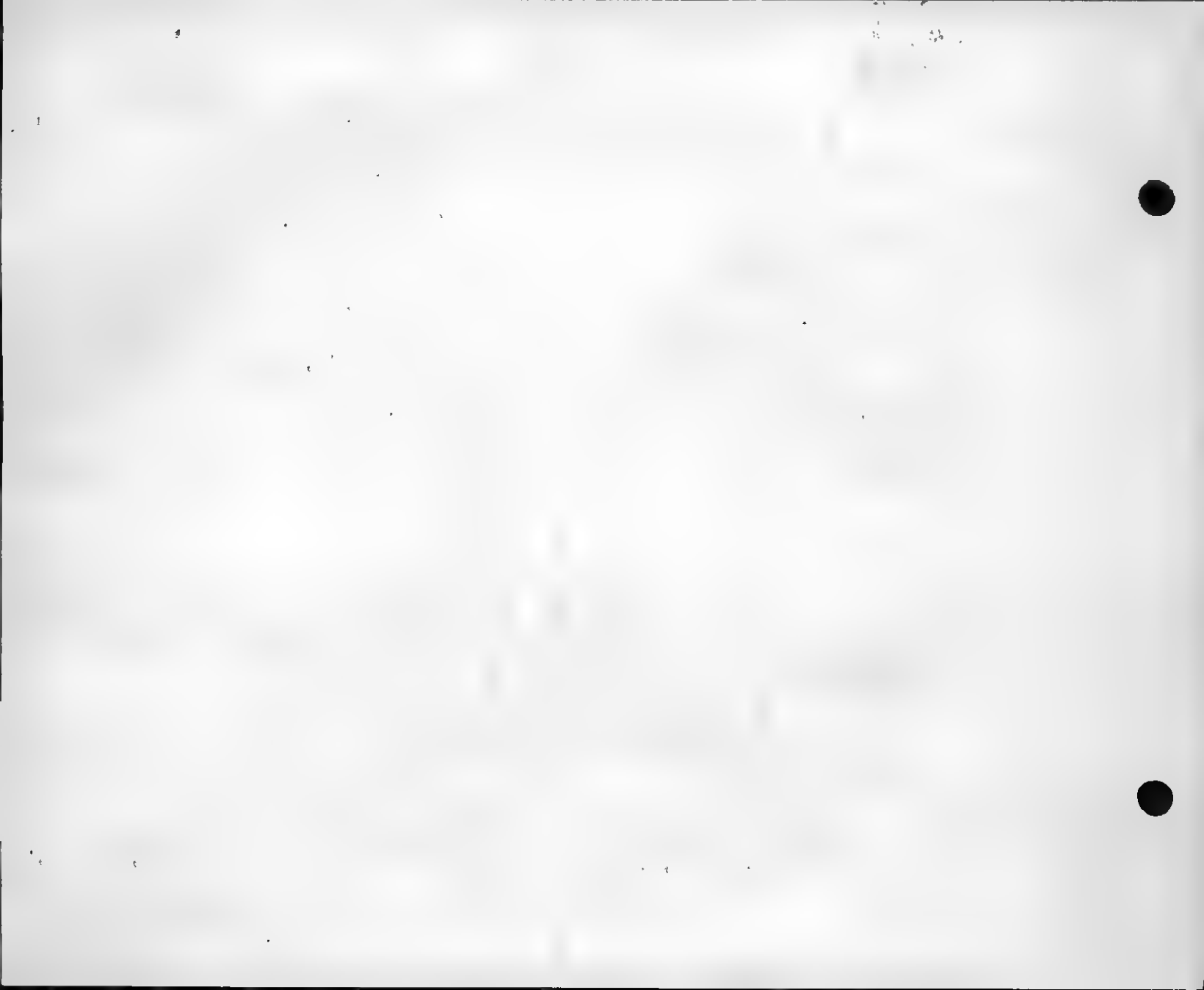
04118

CERTIFICATE OF DEATH

04117

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b 1			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d. STREET ADDRESS 5418 WALTON AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD LIAM PAWLAK				4. DATE OF DEATH Month Day Year MARCH 22 1967			
5. SEX MALE	6. COLOR OR RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 FEBRUARY 67		9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months Days Hours Min 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY NA		11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY J. PAWLAK				14. MOTHER'S MAIDEN NAME RUTH C. CHAPMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NA		17. INFORMANT RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 7777 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Respiratory Insufficiency DUE TO (c) Sudden Death in Infancy							INTERVAL BETWEEN ONSET AND DEATH 8 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 22 March, 1967 to 22 March, 1967 that (I) (we) last saw the deceased alive on 22 March, 1967 , and that death occurred at 10:00 PM , from causes and on the date stated above.							
22a. SIGNATURE Herrick J. Cohen				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 22 March 67	
22c. PHYSICIAN'S NAME (Type) HERRICK J. COHEN, CAPTAIN USAF MC				22d. ADDRESS USAF HOSPITAL ANDREWS AFB, WASH 25, DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/27/67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR ROBERT E. WILHELM 4308 SUITLAND RD. SUITLAND, MARYLAND				25a. REC'D BY REGISTRAR DATE MAR 28 1967			
				25b. REC'D BY SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT

M

05685

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05685

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, 1 institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS 213 75th. Street	
3. NAME OF DECEASED (Type or print) First Spencer Middle H Last Payne		4 DATE OF DEATH Month 3 Day 30 Year 19 67	
5 SEX male	6 COLOR OR RACE negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6 Nov. 1925
9 AGE (In years last birthday) 41 yrs		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio Dispatcher		10b KIND OF BUSINESS OR INDUSTRY AAA	
11 BIRTHPLACE (State or foreign country) Ohio		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Payne		14 MOTHER'S MAIDEN NAME Lillian Coleman	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Catherine Payne		Address 213 75th St	
18 CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 0 m pm 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 3-31-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/4/67	Lincoln Memorial Ceme.	Maryland
24 FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd.		25a DEPUTY REGISTRAR APR 11 1967	
25b DECEASED'S SIGNATURE Stewart		25c DECEASED'S SIGNATURE Stewart	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

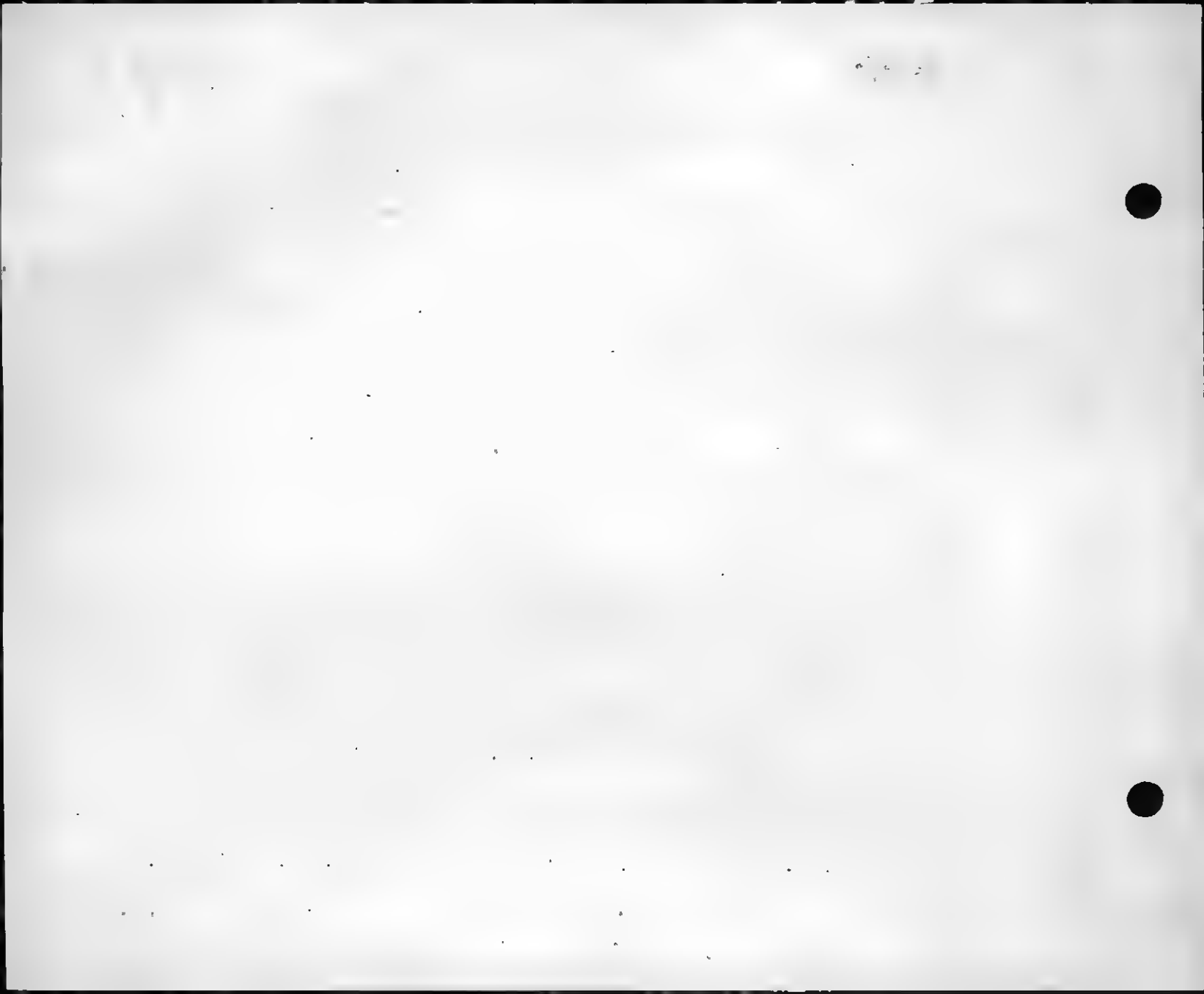
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3604 Perry Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Teresa Pelle		4. DATE OF DEATH March 16 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Dec., 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) 86 yrs.
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Anthony Varrasse		14. MOTHER'S MAIDEN NAME Angela Rugoro	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Albert DiCarlo		Address (above address)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO (b) Generalized arteriosclerosis OUE TO (c) Recent pneumonia			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 28, 1967 , to March 16, 1967 , that (I) (we) last saw the deceased alive on March 16, 1967 , and that death occurred 12:20 AM from the causes and on the date stated above.			
22a. SIGNATURE Don B. Cameron		22b. DATE SIGNED March 16, 1967	
22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.		22d. ADDRESS 3503 Perry St., Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/18/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town or county) (State) Washington, D.C.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR MAR 20 1967	
ADDRESS Mt. Rainier, Maryland		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

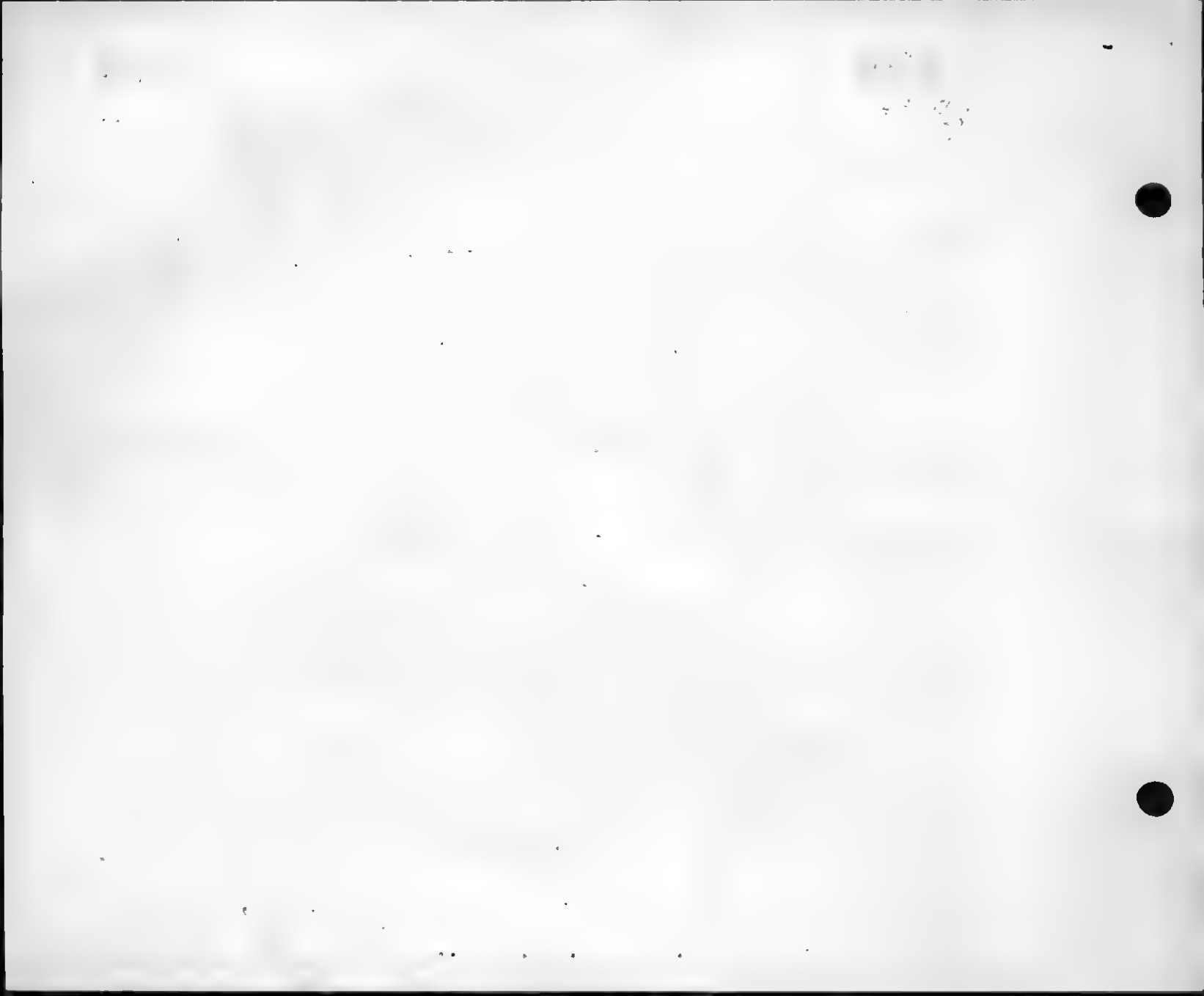


04119

Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 3/67



12 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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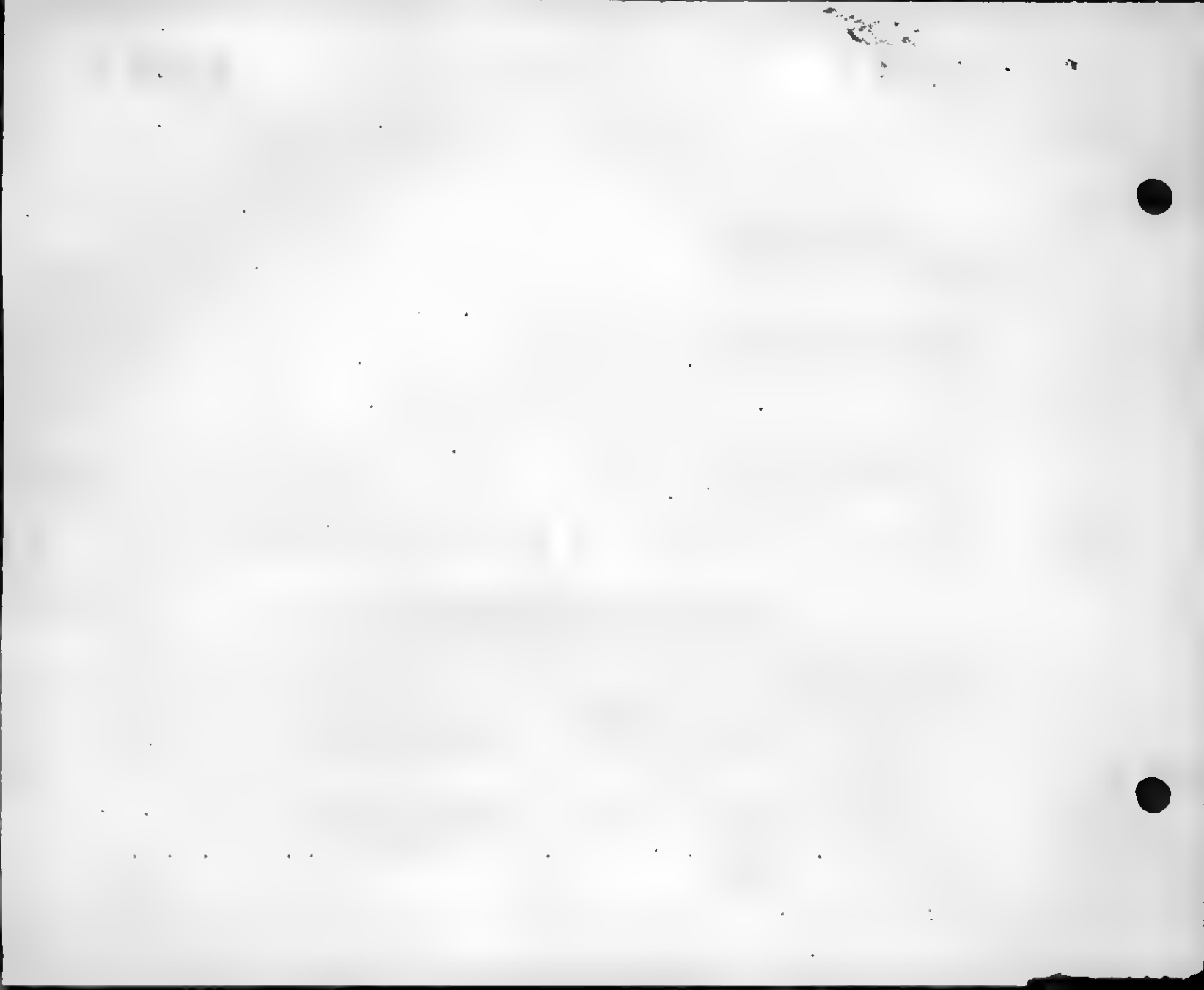
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04121

CERTIFICATE OF DEATH

04120

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS 5611-Old Temple Hills RD SE	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH N. PORTER		4 DATE OF DEATH Month Day Year March 14th 1967	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 25, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Washington Gas Light Co.		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 52 yrs
11 BIRTHPLACE (County & State, or foreign country) Washington, DC		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Madison C. Porter		14. MOTHER'S MAIDEN NAME Emma S. Baldwin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 577 07 7981	17 INFORMANT Ruth M. Porter (Wife) Same as Item #2
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> (c)			INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Essential Hypertension</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/16</u> , 19 <u>66</u> , to <u>3/14</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>3/9</u> , 19 <u>67</u> and that death occurred at <u>3 P</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>S. W. Nealon Jr.</u>		22b. DATE SIGNED Mar. 15-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Stephen W. Nealon, Jr.		22d ADDRESS 1746-K-St., N.W. Wash. D. C.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar. 17-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a REC'D BY REGISTRAR MAR 16 1967	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

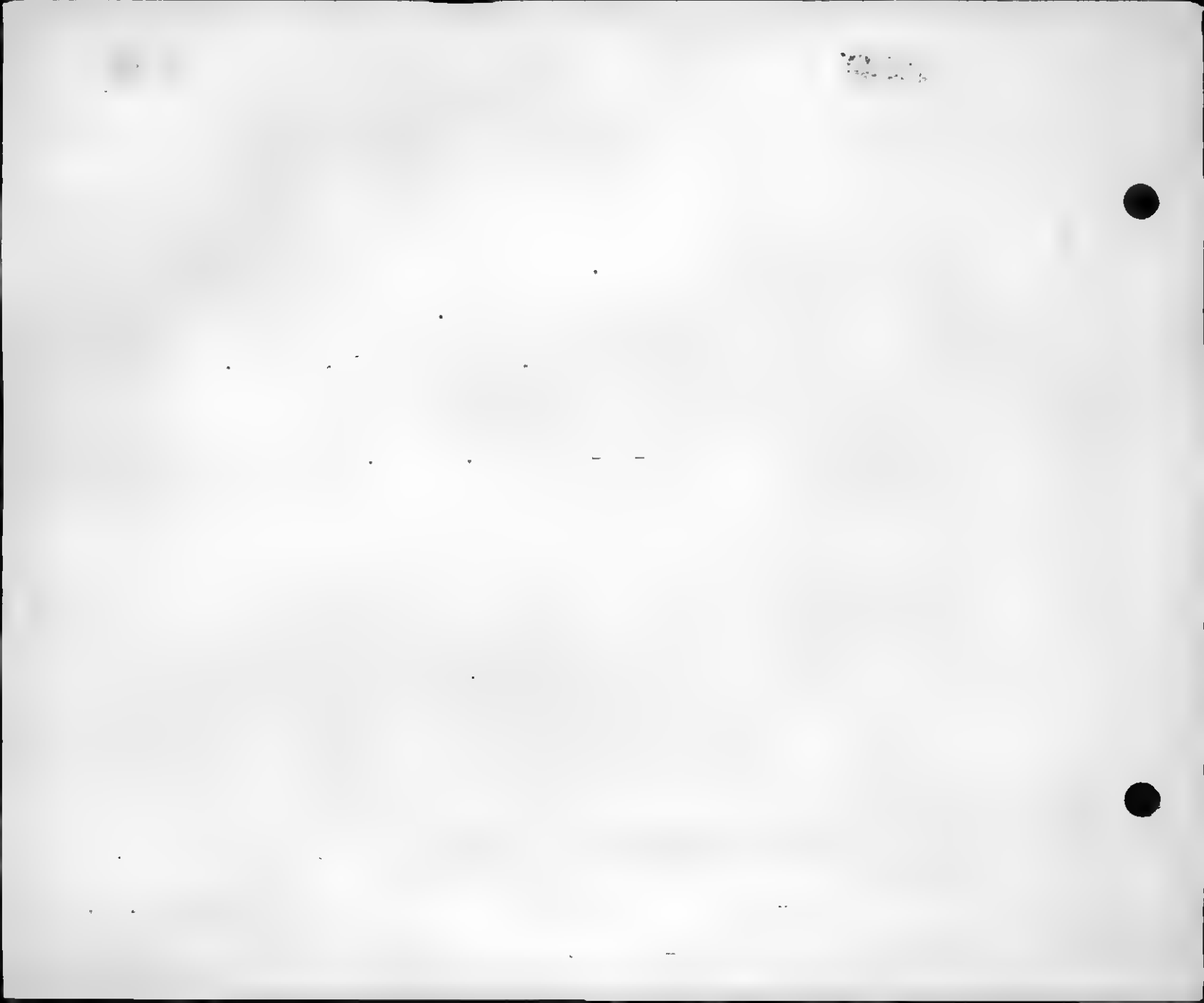
04122

CERTIFICATE OF DEATH

04121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor				d. STREET ADDRESS 11419 Lund Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hannah Middle A. Last Powderly				4. DATE OF DEATH Month March Day 29 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1890		9. AGE (In years last birthday) 76 yrs	10. UNDER 1 YEAR Months Days Hours Min. 	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Clerk		10b. KIND OF BUSINESS OR INDUSTRY Civil Service Comm.		11. BIRTHPLACE (County & State or foreign country) Carbondale, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Powderly				14. MOTHER'S MAIDEN NAME Catherine Loftus			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-48-4633		17. INFORMANT Mrs. John C. Lynch		Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ulcerative Colitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) this hospital attended the deceased from April 7 , 19 65 , to March 29, 1965 , that (I) was last saw the deceased alive on March 29 , 19 67 , and that death occurred at 6:10 a.m. from causes and on the date stated above.							
22a. SIGNATURE Thomas F Collins				22b. DATE SIGNED 3/29/67		22c. PHYSICIAN'S NAME (Type) Thomas F Collins, M.D.	
22d. ADDRESS B22 H St. N.E. Washington, D.C. 20002				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-31-67		23c. NAME OF CEMETERY OR CREMATORIAL Mount Olivet		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Francis J. Collins				25a. RECD BY REGISTRAR MAR 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE HEALTH DEPT

04123

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04122

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY In lb DOA		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchelville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS RTE. 1, Box 1118 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last James Ryan Proctor		4 DATE OF DEATH Month Day Year 3 24 1967	
5 SEX male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-19-66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs 3 5 Months Days Hours Min
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME James Brown		14 MOTHER'S MAIDEN NAME Barbara Proctor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. NONE	
17 INFORMANT Barbara Proctor		Address Rt. 1 Box 1118	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Undetermined (SDII) DUE TO Associated with pulmonary congestion, bilateral SDII and pulmonary atelectasis, focal Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) SDII DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4-5	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9	20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		22. DATE SIGNED 3-25-67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-28-67	23c. NAME OF CEMETERY OR CREMATORY Church Cemetery	23d. LOCATION (City or Town) (County) (State) Mitchelville, Maryland
24 FUNERAL DIRECTOR ROLLINS FUNERAL HOME		25. REC'D BY REGISTRAR Charles Judge DATE MAR 29 1967	
25b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

44



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04124

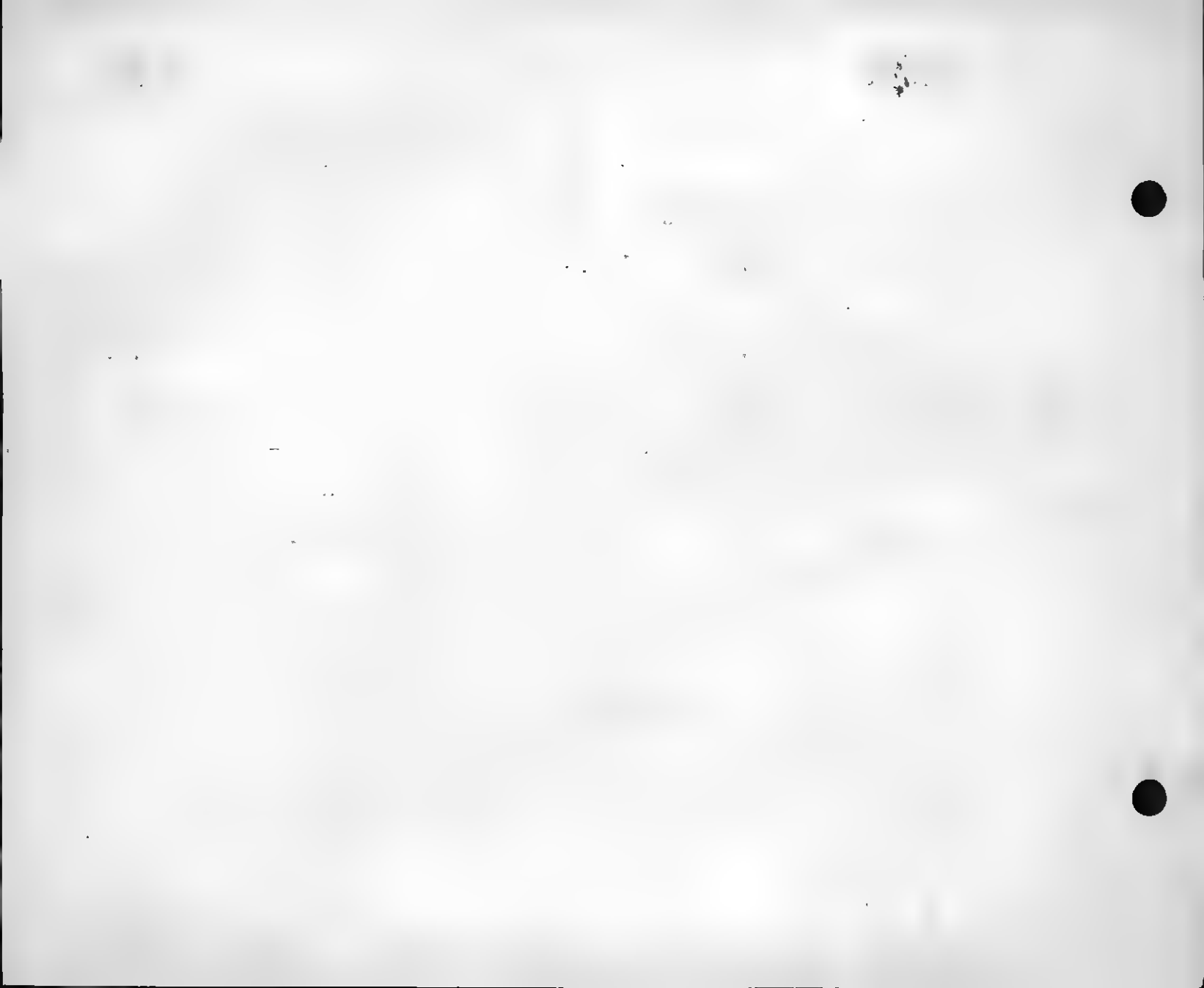
CERTIFICATE OF DEATH

04123

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write-RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 8313 Bock Road			
3. NAME OF DECEASED (Type or print) John First J. C. Middle Proctor Last				4. DATE OF DEATH Month March Day 4 Year 19 67			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/21/03	
9. AGE (In years last birthday) 63 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Proctor		14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-16-2548		17. INFORMANT Mary Helen Harley-Daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction acute DUE TO (b) Acute Coronary Occlusion. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 2, 19 67, to March 4, 19 67, that (I) (we) last saw the deceased alive on March 4, 19 67, and that death occurred at 11:45 AM from causes and on the date stated above.							
22a. SIGNATURE R. U. FRANCHI				22b. DATE SIGNED 3-6-67		22c. PHYSICIAN'S NAME (Type) R. U. FRANCHI	
22d. ADDRESS 7729 Finn's Lane Catonsville Md				22e. ATTENDING PHYS <input type="checkbox"/> MED AM DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22f. DATE SIGNED 3-6-67	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		3-8-67		ST. PETERS		WALDORF Charles Md	
24. FUNERAL DIRECTOR ARCHART FUNERAL Home				25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



24 hours after death. Page 4 is retained by the hospital or attending physician. The law requires that the death certificate be executed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04125

CERTIFICATE OF DEATH

04124

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Forestville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Regent Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Prindel</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Lothian</u> d. STREET ADDRESS <u>Lothian</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Mary ROBERTA Prout</u>		4. DATE OF DEATH Month <u>March</u> Day <u>23</u> Year <u>1967</u>		9. AGE (In years last birthday) <u>83</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>23</u> Hours <u>00</u> Min. <u>00</u>
5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 25, 1883</u> 9. WIDOWED <input checked="" type="checkbox"/> 10. DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <u>Lothian, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		13. FATHER'S NAME <u>ISAAC Stanton Notwe II</u> 14. MOTHER'S MAIDEN NAME <u>Robertta Winterson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO <u>Winterson Prout, Lothian, Md</u> 17. INFORMANT <u>Winterson Prout, Lothian, Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain hemorrhage</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> (c) <u>hypertension</u> DUE TO <u>hypertension</u> (e), stating the underlying cause last.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>45 hrs</u> <u>45 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe anemia due to chronic iron defect & chronic infection</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 2-5-1967, to 3-23-1967, that (I) (we) last saw the deceased alive on 3-22-1967, and that death occurred at M, from the causes and on the date stated above.				
22a. SIGNATURE <u>Robert B. Sasser</u> 22c. PHYSICIAN'S NAME (Type) <u>Robert B. Sasser</u>		22b. DATE SIGNED <u>3-23-67</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>upper Marlboro, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3-25-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary</u>		23d. LOCATION (City, town or county) (State) <u>Lothian Md</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Hordorator, Galensville, Md</u> ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 28 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

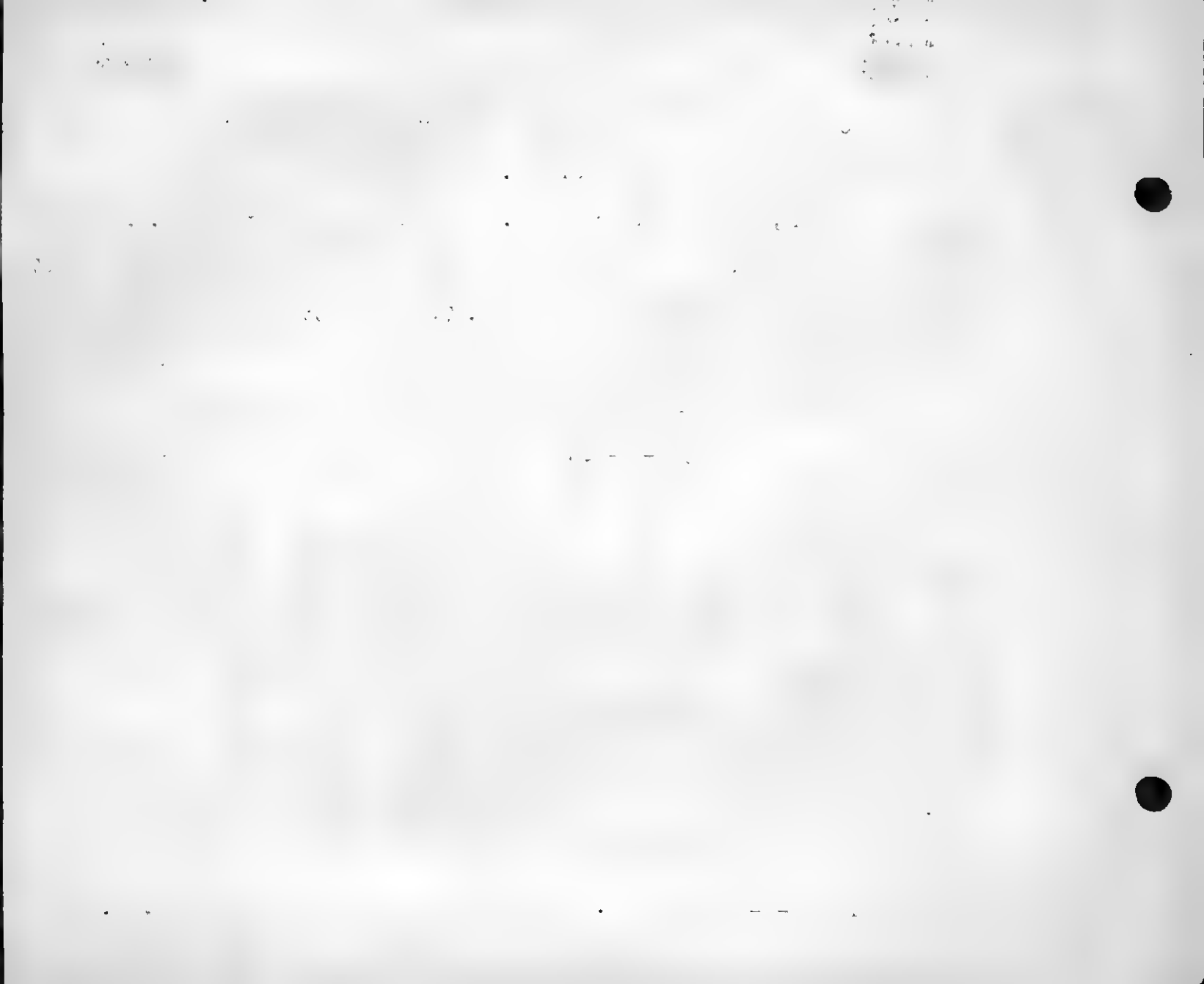
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04126

CERTIFICATE OF DEATH

04125

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 2 years, 2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.			d. STREET ADDRESS 1126 Shepherd Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Agnes Mary Pyne			4. DATE OF DEATH Month Day Year March 31 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1872	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? United States			13. FATHER'S NAME Broderick Petersen		
14. MOTHER'S MAIDEN NAME Agnes Krusa			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO 579-62-6194			17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Heart failure, acute (from coronary thrombosis) 4000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, general					INTERVAL BETWEEN ONSET AND DEATH 1 hour Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1957 , to March 31, 1957 , that (I) was last saw the deceased alive on March 30, 1967 , and that death occurred at 3:45 p.m. from causes and on the date stated above.					
22a. SIGNATURE John F. Brennan Jr.			22b. DATE SIGNED March 31, 1967		22c. PHYSICIAN'S NAME (Type) JOHN F. BRENNAN JR.
22d. ADDRESS 1034 PERRY ST. N.E. WASH. D.C.			22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-4-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
23d. LOCATION (City or Town) Washington, D. C.		23e. (County) (State)		23f. (County) (State)	
24. FUNERAL DIRECTOR WALSH'S FUNERAL HOME			25. REG'D BY REGISTRAR APR 3 1967		
26. ADDRESS 3821 14th ST. N.W. WASH. D.C.			27. REGISTRAR'S SIGNATURE J. J. Jones		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04127

CERTIFICATE OF DEATH

04126

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE Maryland b COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 59 days			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d STREET ADDRESS 4834 - 69th Place			
3 NAME OF DECEASED (Type or print) First Middle Last William J. - Quigley				4 DATE OF DEATH Month Day Year March 10, 1967			
5. SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/5/90	9. AGE (In years lost birthday) 76 yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter (Ret'd)			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Delaware		12: CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Quigley				14. MOTHER'S MAIDEN NAME Elizabeth Bridgeman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 578-20-5876		17 INFORMANT Mrs. Bernard L. Zeimetz #2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL CA PANCREAS</u> 157X DUE TO (b) <u>C METASTASIS TO BRAIN, LUNGS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>LIVER</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>March 10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 10</u> , 19 <u>67</u> , and that death occurred at <u>8:00</u> M. from causes and on the date stated above.							
22a SIGNATURE <u>Thomas G. Maloney</u>			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED March 10, 1967		
22c PHYSICIAN'S NAME (Type) Thomas G. Maloney			22d ADDRESS 4814 - 71st Ave. Landover, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		3/13/67		Fort Lincoln		Bladensburg, Maryland	
24 FUNERAL DIRECTOR ADDRESS F.J. COLLINS 3821-14th ST. N.W. WASH. D.C.				25a. REC'D BY REGISTRAR DATE APR 13 1967		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04128						04127					
1. PLACE OF DEATH a. COUNTY <u>On Geo</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellville and</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				d. STREET ADDRESS <u>10710 Kimloch Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Even Cedars Nursing Home</u>											
3. NAME OF DECEASED (Type or print)		First <u>ELLA</u>		Middle <u>LORENDA</u>		Last <u>RAND</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>25</u> Year <u>1967</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 18, 1886</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge, VT</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK N. MELENDY</u>						14. MOTHER'S MAIDEN NAME <u>CELIA L. STRONG</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>008-03-1141</u>		17. INFORMANT <u>PAUL G. RAND, Same as #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral & generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 8, 1967</u> to <u>Mar 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 16, 1967</u> , and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>W. L. Etienne</u>						22b. DATE SIGNED <u>3/25/67</u>		22c. PHYSICIAN'S NAME (Type) <u>W. L. ETIENNE</u>			
22d. ADDRESS <u>College Park, Md</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>				23b. DATE THEREOF <u>MAR 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEE FUNERAL HOME</u>		23d. LOCATION (City, town or county) (State) <u>WASH. DC.</u>			
24. FUNERAL DIRECTOR <u>Howard S. Wade</u>						ADDRESS <u>Samuel, Md</u>		25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>						DATE					

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Handwritten text in Arabic script, possibly a signature or a specific section header.

Handwritten text in Arabic script, likely the main body of the document, possibly a list or a detailed account.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

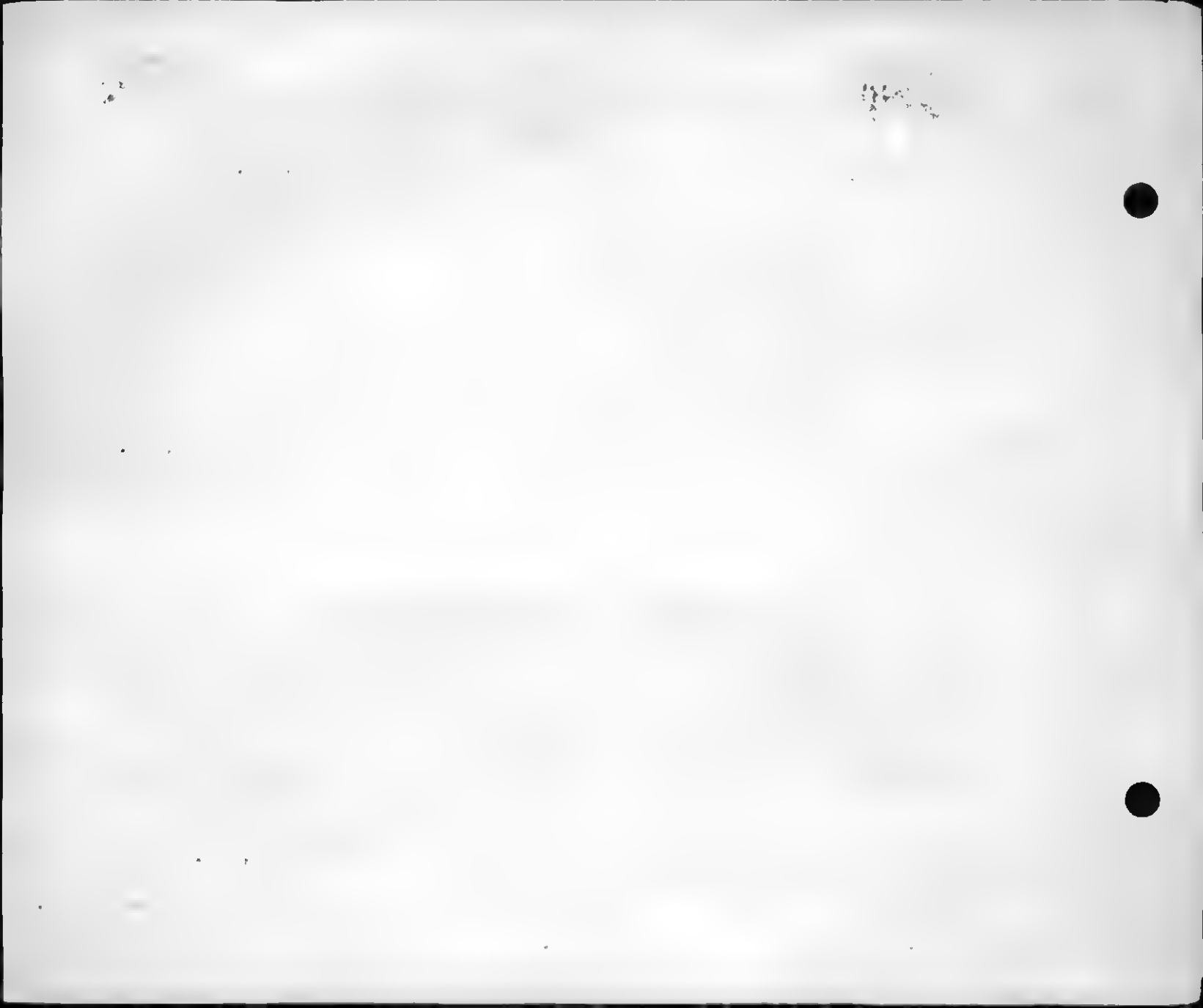
04129

04128

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md		c. LENGTH OF STAY IN lb 12 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.		16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 6504 Truman Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William R Reid sr		4. DATE OF DEATH Month Day Year March 23, 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 14, 1911
9. AGE (in years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas J Reid		14. MOTHER'S MAIDEN NAME Ettie M Orme	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 577 10 7255	
17. INFORMANT Elinor B Reid		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1661 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Benign Squamous Carcinoma DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1967 , to March 23, 1967 , that (I) (we) last saw the deceased alive on March 22, 1967 , and that death occurred at 11:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE A. Deitz		22b. DATE SIGNED March 23, 1967	
22c. PHYSICIAN'S NAME (Type) A Deitz		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar 25, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



04130

CERTIFICATE OF DEATH

04129

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarden</u>				c. LENGTH OF STAY IN 1b <u>6. Year</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8606 Hamlin Street</u>				d. STREET ADDRESS <u>8606 Hamlin</u>			
3 NAME OF DECEASED (Type or print) <u>Joseph H. Ridgley</u>				4 DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1967</u>			
5 SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1875</u>		9 AGE (In years last birthday) <u>92</u> yrs	10 IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>navy</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13 FATHER'S NAME <u>Robert Ridgley</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Green</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16 SOCIAL SECURITY NO <u>579-246325</u>		17. INFORMANT <u>Katie Ridgley</u> Address <u>8606 Hamlin St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) <u>Hyperbension</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 months</u> <u>1 yr.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 10, 1966</u> to <u>March 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-18-1967</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>John G. Todd</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>3-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John G. Todd M.D.</u>				22d. ADDRESS <u>8 Rhode Island Ave, N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-22-1967</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>7601 Shady Rd. Landover 960.D.</u>	
24 FUNERAL DIRECTOR <u>Oscar Barnes - 419-15th St S.E. D.C.</u>				25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. This should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04131

Item #9 Film #3357 3/27/67 DC

CERTIFICATE OF DEATH

04130

1. PLACE OF DEATH a. COUNTY Pr. George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 5 Min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beltsville d. STREET ADDRESS 3700 Sellman Rd.		
3. NAME OF DECEASED (Type or print) First Middle Last Katie Lillian Riley			4. DATE OF DEATH Month Day Year March 19 1967		
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1903		9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME ? Jordan			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Dock M. Riley-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus					INTERVAL BETWEEN ONSET AND DEATH One day Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 - 19, 1960, to 3 - 19, 1967, that (I) (we) last saw the deceased alive on 3 - 15, 1967, and that death occurred at 7 PM, from the causes and on the date stated above.					
22a. SIGNATURE L.W. Malin			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 22d. ADDRESS 404 Queensbury Rd. Riverdale, Md.		22b. DATE SIGNED 20 March, '67
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/67	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Md.
24. FUNERAL DIRECTOR Lyon Wheeler		ADDRESS 1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR MAR 23 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

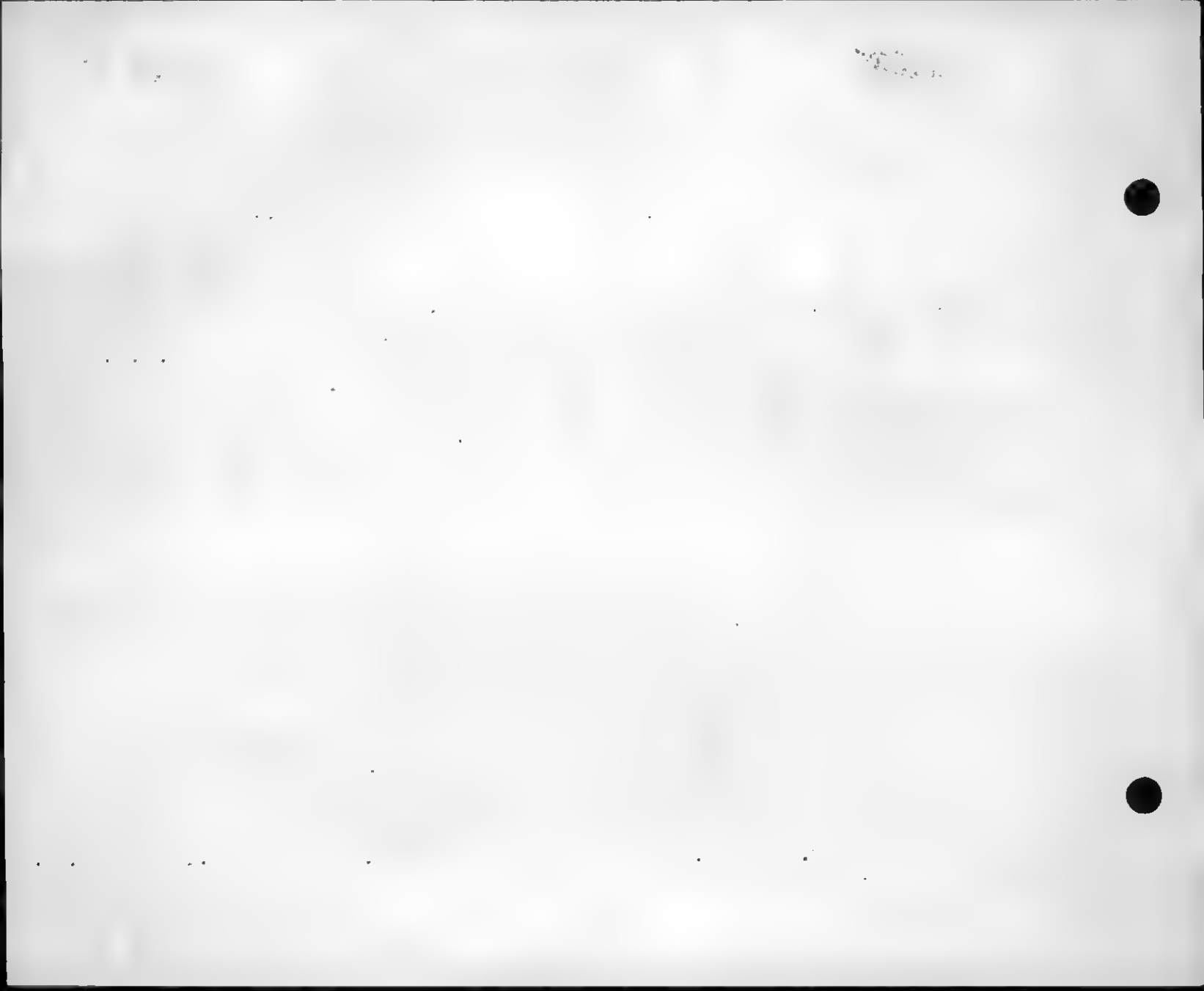


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04132 CERTIFICATE OF DEATH 04131

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover d. STREET ADDRESS 3123 75th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosa M Rivera		4. DATE OF DEATH Month Day Year March 7 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Oct., 1893
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Portaucaica		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Victor Rivera		14. MOTHER'S MAIDEN NAME Maria A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219 54 8830	
17. INFORMANT T Mary Nieves		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Coronary Artery Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of lung & pneumonia INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/4, 1967, to 3/7, 1967, that (I) (we) last saw the deceased alive on 3/7, 1967, and that death occurred at 4:25 AM, from the causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED 3/7/67	
22c. PHYSICIAN'S NAME (Type) Dr. Edwin J. Jensen		22d. ADDRESS Prince Geo. General Hosp., Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-9-1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION (City, town or county) (State) Wash. D.C.	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR MAR 8 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

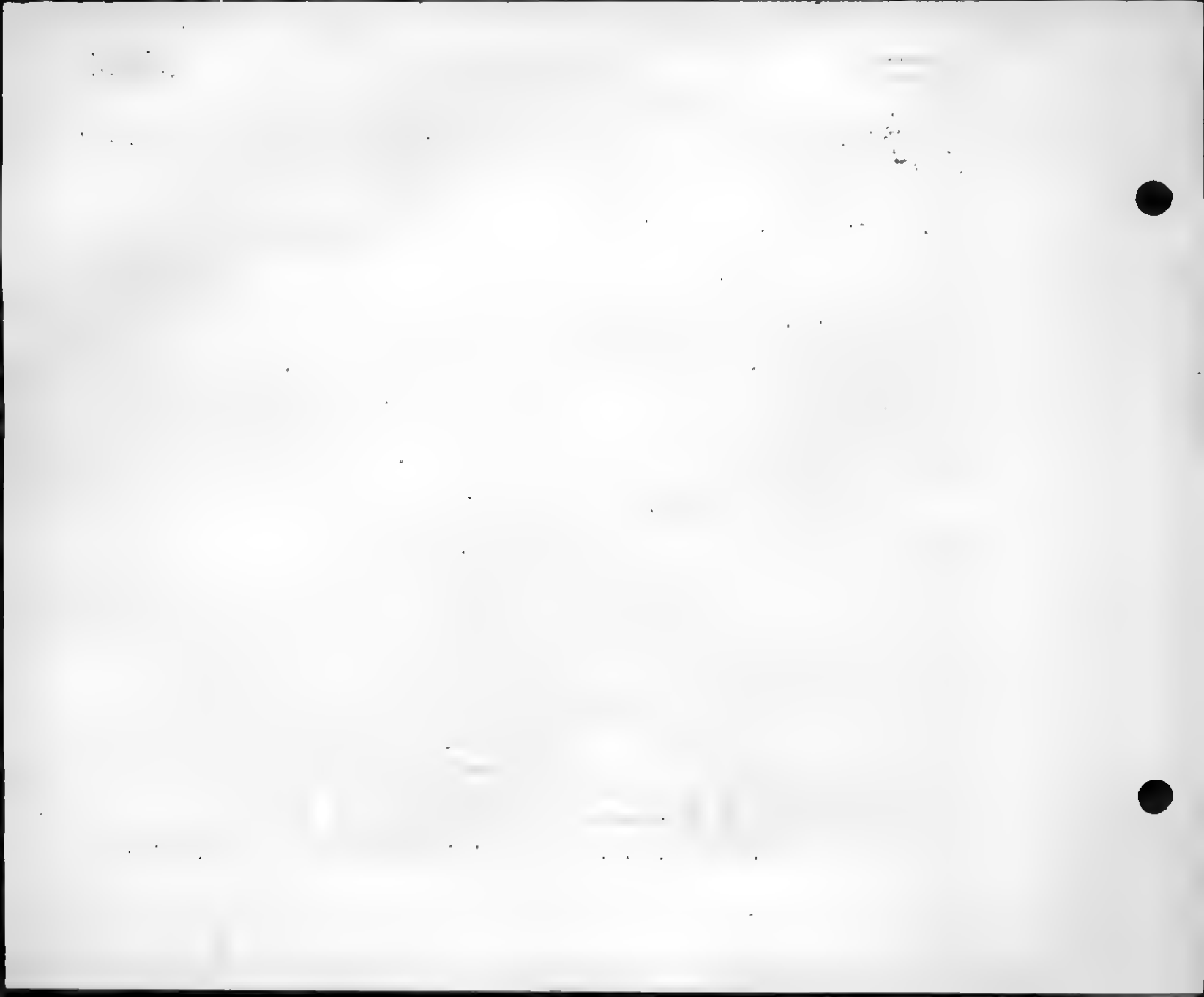
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #G387 11/5/67 DC

04133

CERTIFICATE OF DEATH

04132

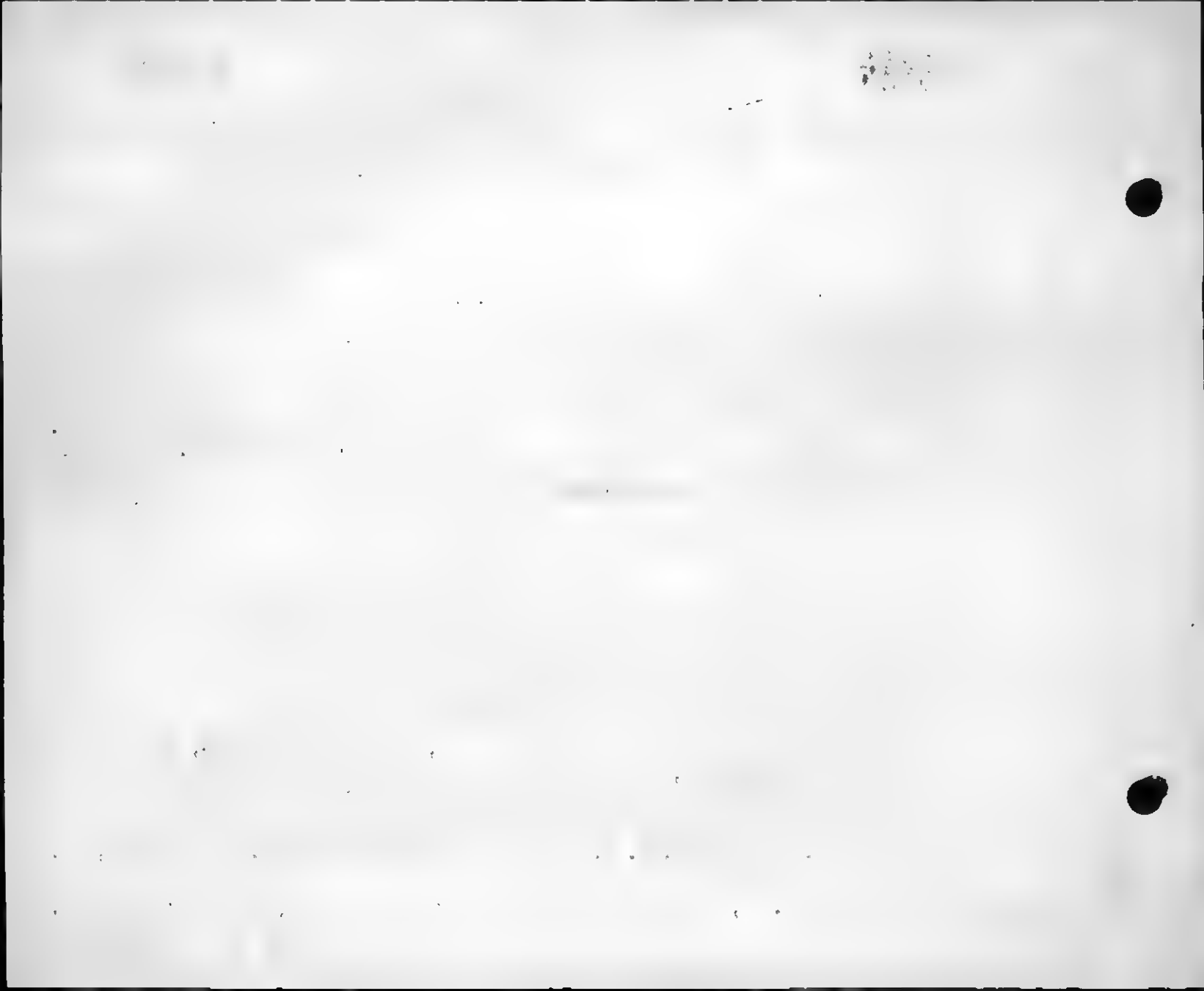
1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 7624 Kilmer Street	
3 NAME OF DECEASED (Type or print) Joseph Rogers		4 DATE OF DEATH Month March Day 23 Year 1967	
5. SEX Male	6 COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-10-84/1883
9 AGE (In years last birthday) 83 yrs		10 IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Foreman, Brick Co.		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) King George Co., Va.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John Rogers		14 MOTHER'S MAIDEN NAME Catherine Trigger	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO	
17 INFORMANT 6917 DECATUR RD APT 2, Hyattsville, Md. Josenh L. Rogers		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Coronary Artery Disease DUE TO (c) Atrial Fibrillation		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Breast Cancer		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-13 , 19 67 , to 3-23 , 19 67 ; that (I) (we) last saw the deceased alive on 3-23 , 19 67 , and that death occurred at 6:35 PM , from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED March 24, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-27-67	
23c. NAME OF CEMETERY OR CREMATORY Grace		23d. LOCATION (City or Town) (County) (State) King George Co., Virginia	
24. FUNERAL DIRECTOR J. Gasch's Sons 4738 B & 17th, Hyattsville, Md.		25a. REC'D BY REGISTRAR MAR 28 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04134						04133					
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt c. LENGTH OF STAY IN 1b Unknown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 B Ridge Road						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt, Md. d. STREET ADDRESS 3B Ridge Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mabel Maria Rolph			4. DATE OF DEATH March 9, 1967			5. SEX Female			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5-1-00			9. AGE (in years last birthday) 66 yrs.			10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Louis Jehle						14. MOTHER'S MAIDEN NAME Mary Elizabeth Wagner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Samuel Rolph, 3B Ridge Rd. Greenbelt, Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1 month 1050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Adenocarcinoma of colon (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 1 month											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from October 13, 1966 to March 9, 1967 , that (I) (we) last saw the deceased alive on March 6, 1967 , and that death occurred at 3:10 P.M. from the causes and on the date stated above.											
22a. SIGNATURE C. J. Houmann M.D.						22b. DATE SIGNED 3-9-67			22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D.		
22d. ADDRESS 4404 Queensbury Rd. Riverdale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Mar. 13, 1967		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery, Hyattsville, Md.			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale Md.						25a. REC'D BY REGISTRAR Charles Judge			25b. REGISTRAR'S SIGNATURE Charles Judge		
DATE MAR 13 1967											



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME '5
6M '67

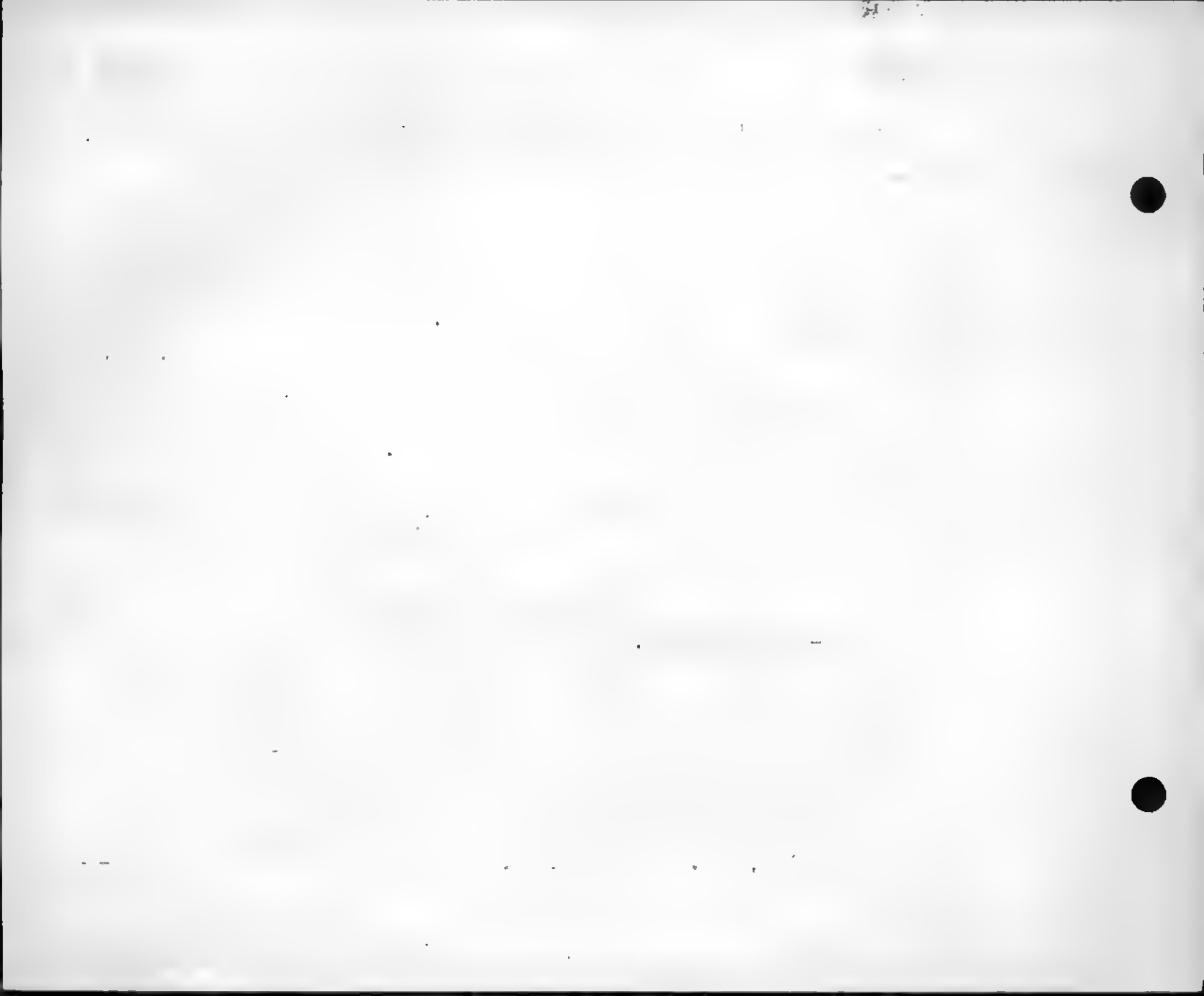
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04134

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY N to Ib DOA	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e STREET ADDRESS 6307 Joslyn Place	
3 NAME OF DECEASED (Type or print) First Agnes Middle Rooney Last Rooney		4 DATE OF DEATH Month 3 Day 7 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1 Feb. 1878
9 AGE (In years last birthday) 89 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Ireland	
12 CITIZENSHIP OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Jeremiah O'Connor	
14 MOTHER'S MAIDEN NAME Margaret Curtin		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO 577 07 7618D		17 INFORMANT Address Joseph L. Rooney Same as # 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 20 years.			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Keproe, M.D.		22. DATE SIGNED 3-8-67	
EXAMINER'S NAME (Type) John Keproe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 3-10-1967	23c NAME OF CEMETERY OR CREMATORY Cedar Hill	23d LOCATION (City or town) (County) (State) Suitland, Md
24 FUNERAL DIRECTOR Robert A. Mattingly		25a REC'D BY REGISTRAR MAR 10 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		Address Wash, 13th St S	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

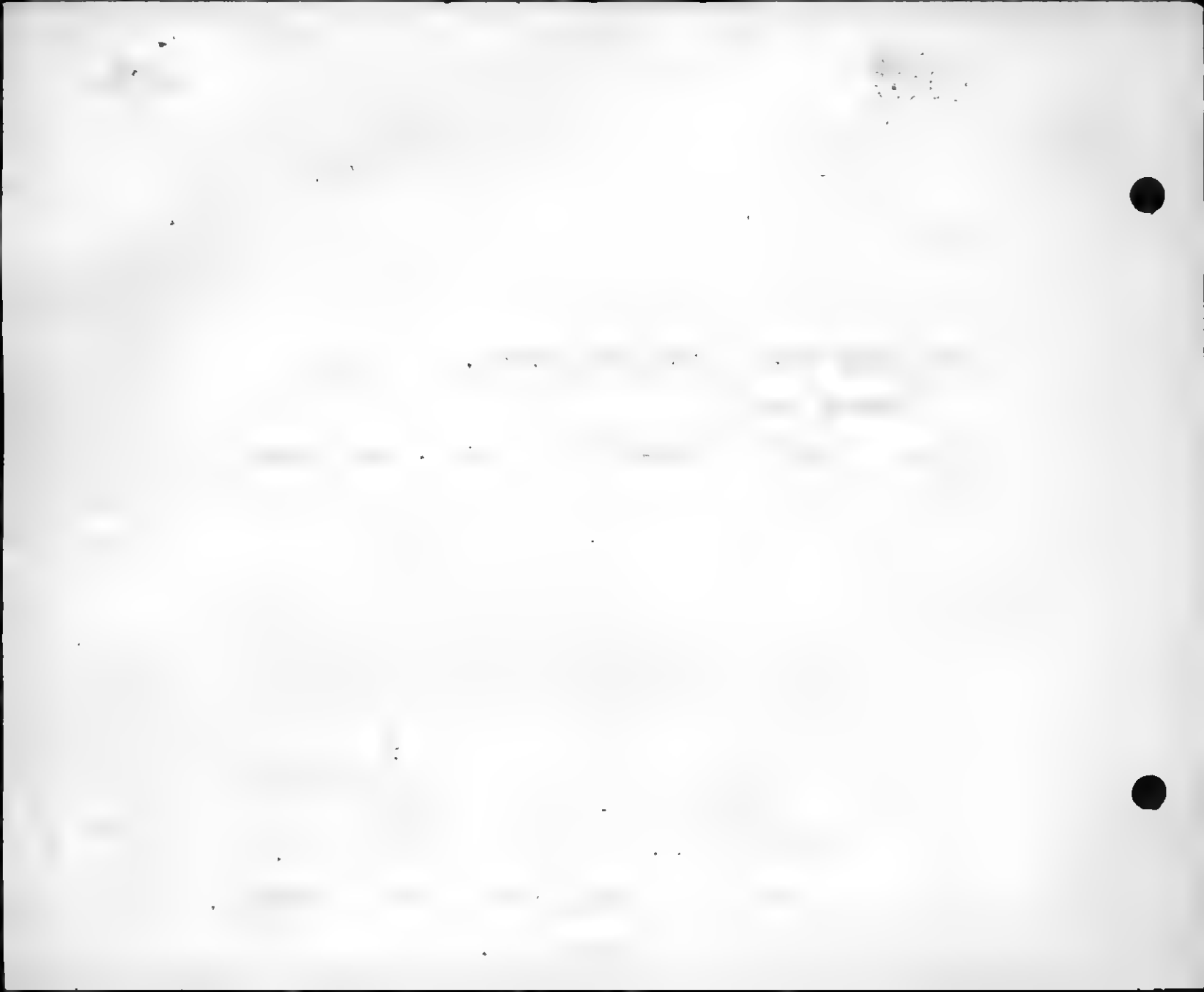
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04136

04135

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Baltimore	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN IB DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		e STREET ADDRESS Box 767 Rt. 1 Beck Ave.	
3 NAME OF DECEASED (Type or print) First Middle Last Herman Vincent Root		4 DATE OF DEATH Month Day Year March 4 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 5, 1916
9 AGE (In years last birthday) 50 yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b KIND OF BUSINESS OR INDUSTRY Sheet Metal Contract.	
11 BIRTHPLACE (State or foreign country) Baltimore		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Jessie Root		14 MOTHER'S M A DEN NAME ?	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16 SOC AL. SECURITY NO 218-07-2800	
17 INFORMANT Marie J. Root		Address Same	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) over 3 yrs		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-4-67	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3/8/67	
23c NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d LOCATION (City or town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.		25a REC'D BY REGISTRAR MAR 7 1967	
25b SIGNATURE John Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04137

CERTIFICATE OF DEATH

04136

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEO. CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST HYATTSVILLE		c. LENGTH OF STAY IN b 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HYATTSVILLE NURSING HOME		d. STREET ADDRESS 500 CHILLUM RD.	
3. NAME OF DECEASED (Type or print) LOUIS BENJAMIN ROSENTHAL		4. DATE OF DEATH Month MARCH Day 16 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 1, 1913
9. AGE (In years last birthday) 53 yrs.		10. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK	
10b. KIND OF BUSINESS OR INDUSTRY FACTORY		11. BIRTHPLACE (County & State, or foreign country) HARTFORD-CONNECTICUT	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME SAMUEL ROSENTHAL	
14. MOTHER'S MAIDEN NAME SCHUMAN, ROSE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO 047-10-8730		17. INFORMANT ROBERT ROSENTHAL Address 500 CHILLUM RD. HYATTSVILLE MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malignant Glioblastoma 1957 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 1966, to 3-16 , 1967, that (I) (we) last saw the deceased alive on 3-15 19 67 and that death occurred at 9 A.M. , from causes and on the date stated above			
22a. SIGNATURE Gilbert B. Cushman M.D.		22b. DATE SIGNED 3-16-67	
22c. PHYSICIAN'S NAME (Type) GILBERT B. CUSHNER		22d. ADDRESS 11161 New Hampshire Ave. Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 20, 1967	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or town) (County) (State) Rocky Hill, Conn.
24. FUNERAL DIRECTOR Arthur Watson, 254 Carroll St. N. Wash. D.C.		25. REC'D BY REGISTRAR DATE MAR 23 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04138					04137				
1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Pr. Geo. Co.</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chesley</i>			c. LENGTH OF STAY IN 1b <i>D.O.A.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>University Park</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Prince Georges General Hospital</i>					d. STREET ADDRESS <i>6905 40th Avenue</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>VICTOR</i> Middle <i>OWEN</i> Last <i>ROY</i>					4. DATE OF DEATH Month <i>March</i> Day <i>26</i> Year <i>1967</i>				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 4, 1912</i>		9. AGE (In years last birthday) <i>54</i> yrs. IF UNDER 1 YEAR: Months <i>54</i> Days <i>54</i> Hours <i>54</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Federal Government</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Lept. of Ag. F.H.A.</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Alabama</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Louis Roy</i>					14. MOTHER'S MAIDEN NAME <i>Mary Courtney</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <i>Family of Deceased (same as #2)</i> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i> <i>9 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> to <i>Feb</i> , 1967, that (I) (we) last saw the deceased alive on <i>Feb 27</i> 1967, and that death occurred at <i>M</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Arthur B. Rosenbaum</i> M.D.					22b. DATE SIGNED <i>3/26/67</i>				
22c. PHYSICIAN'S NAME (Type) <i>ARTHUR B ROSENBAUM</i>					22d. ADDRESS <i>2121 Pennsylvania Ave NW</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>March 29, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Montgomery Co. Md.</i>		
24. FUNERAL DIRECTOR <i>Arthur Walters</i> ADDRESS <i>254 Carroll St. N.W. W.C.</i>					25a. REC'D BY REGISTRAR <i>Mar 28 1967</i> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

Arthur Walters

note: cleared by coroner

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04139

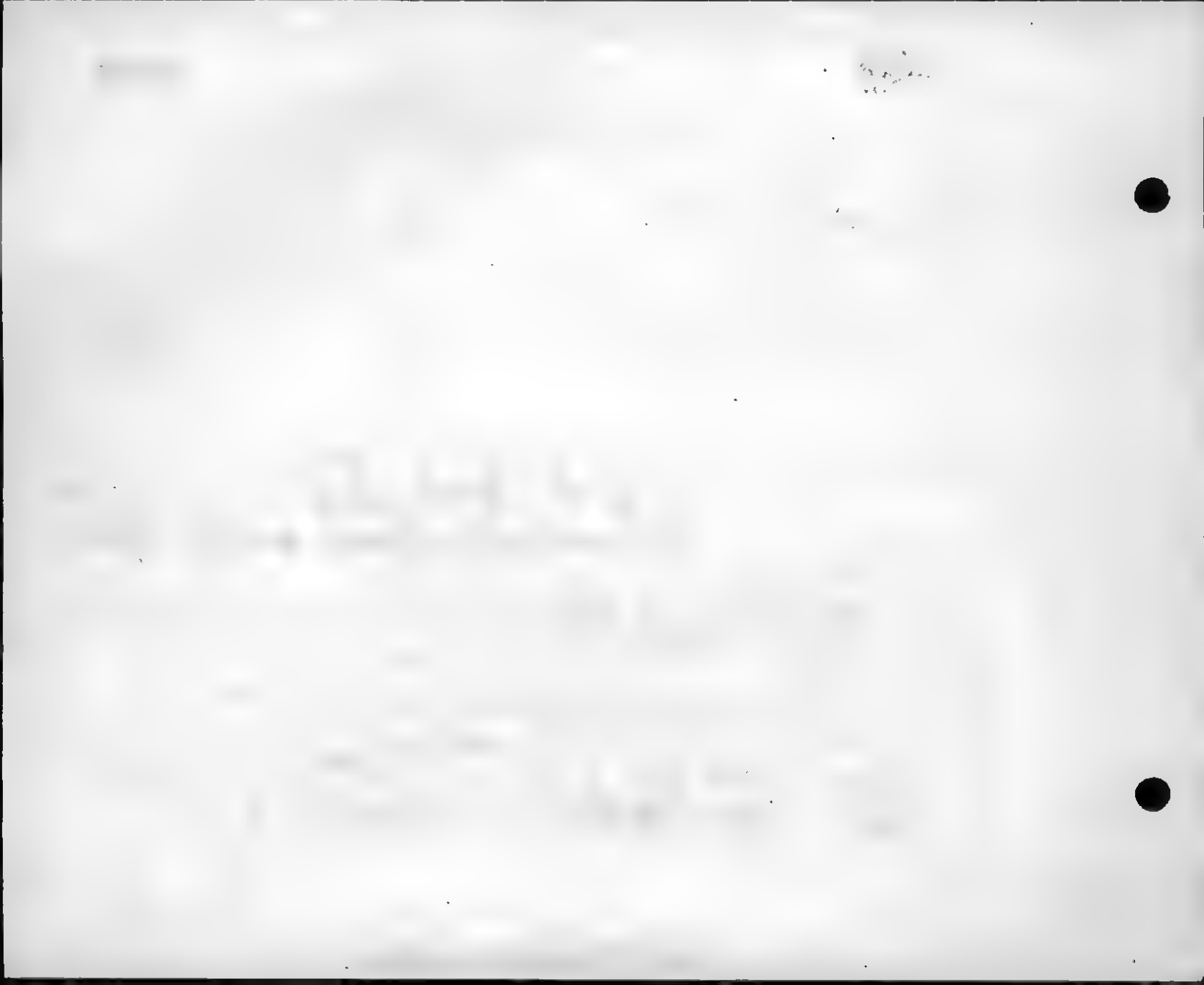
CERTIFICATE OF DEATH

04138

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENBELT				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREENBELT CONVALESCENT CENTER 1010 GREENBELT RD				d. STREET ADDRESS 1613 RIDGE ROAD			
3. NAME OF DECEASED (Type or print) First ALICE Middle SCHAEFFER Last				4. DATE OF DEATH Month MAR Day 11 Year 1967			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1885	
9. AGE (In years at birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ALFRED H KUHN				14. MOTHER'S MAIDEN NAME MARY PETERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT PAUL A KUHN Address ROUTE 3 ALLENTOWN PA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Oxley nephritis							INTERVAL BETWEEN ONSET AND DEATH 2 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 P.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-20-66 , 19__ to 3-11-67 , 19__, that (I) (we) last saw the deceased alive on 3-10-67 , 19__, and that death occurred at 2:00 P.M. from causes and on the date stated above.							
22a. SIGNATURE W.C. Weintraub				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) William C. Weintraub, M.D.	
22d. ADDRESS 115 Centerway, Greenbelt, Md. 20770				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-15-1967		23c. NAME OF CEMETERY OR CREMATORY JORDON LUTHERAN CEM		23d. LOCATION (City or Town) (County) (State) GREENFIELD PA	
24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.				25a. REC'D BY REGISTRAR MAR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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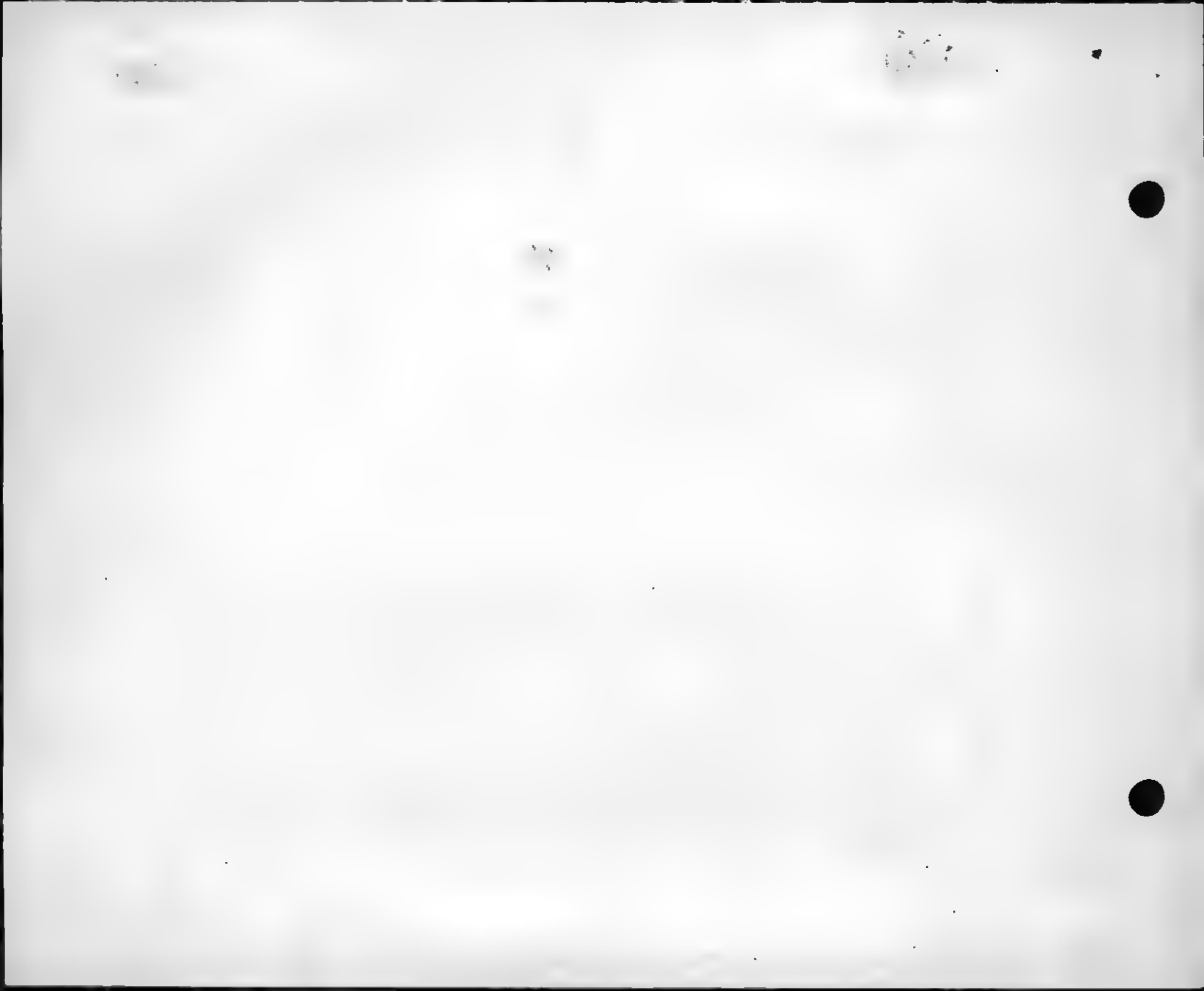
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1

MARYLAND STATE DEPARTMENT OF HEALTH

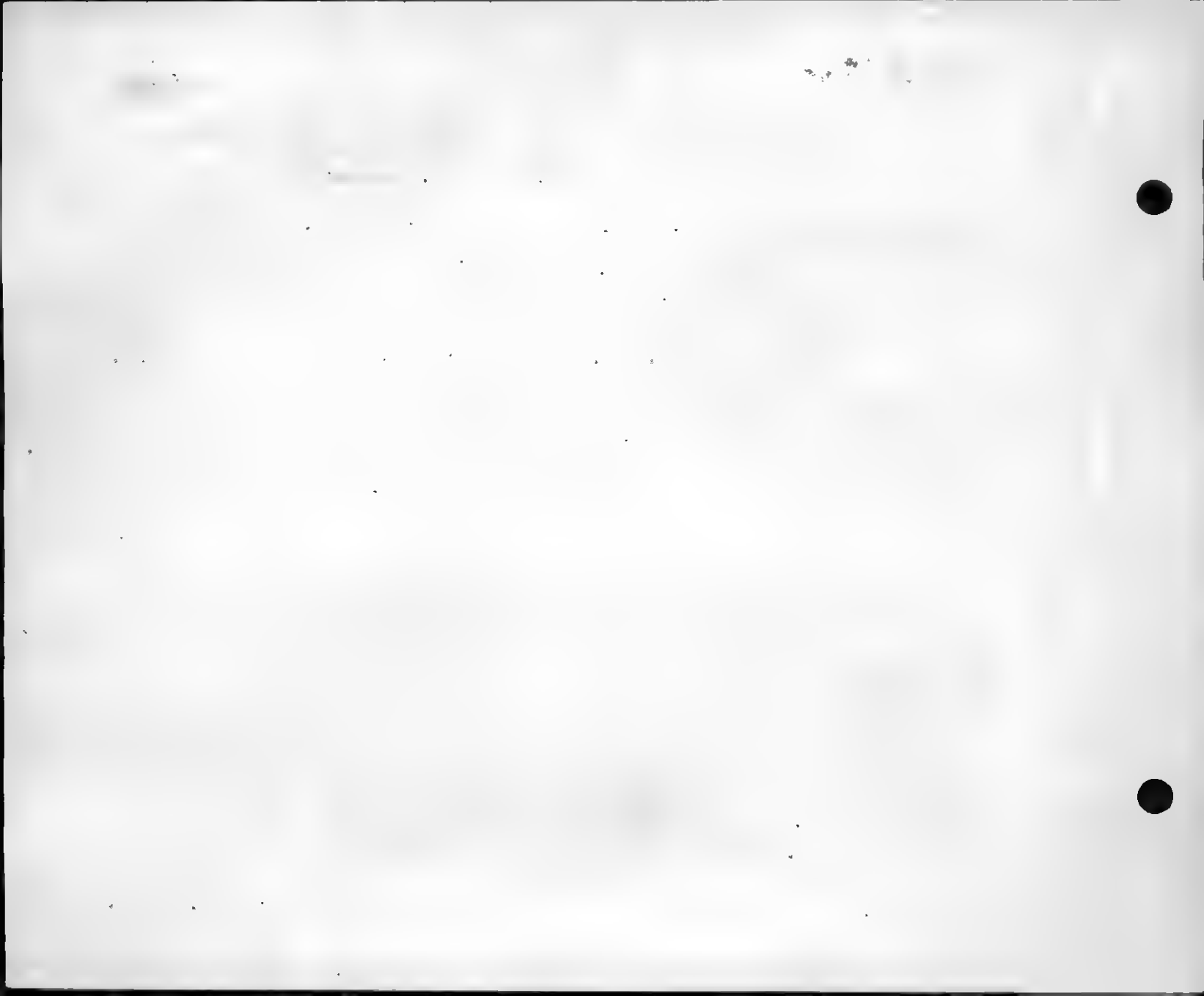
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04141

CERTIFICATE OF DEATH

04140

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3802 - 30th St.	
3 NAME OF DECEASED (Type or print) Charles Wm. Schellinger		4. DATE OF DEATH Month March Day 23 Year 19 67	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/14/05
9. AGE (In years lost birthday) yrs 61		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police		10b. KIND OF BUSINESS OR INDUSTRY Univ. Md. Police	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CIT. ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Washington Schellinger		14. MOTHER'S MAIDEN NAME Florence M Gates	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 577289454	
17. INFORMANT Mildred Schellinger		Address Mt. Rainier, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Atherosclerotic Cerebro-Vascular Ds (b) Diabetes Mellitus DUE TO Compensative Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 3-3-67 year year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from March 23, 1967 , to March 23, 1967 , that (I) (we) last saw the deceased alive on March 23, 1967 , and that death occurred at 3:30 M. from causes and on the date stated above.			
22a. SIGNATURE OKANNES SAHAKYAN		22b. DATE SIGNED 3-23-67	
22c. PHYSICIAN'S NAME (Type) OKANNES SAHAKYAN		22d. ADDRESS 5813 LANDOVER Rd Chevy Chase	
23a. BURIAL, CREMATION, REMOVA. (Specify) Cremation	23b. DATE THEREOF 3-25- 67	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nalley Funeral Home Mt Rainier, Md.		25a. REC'D BY REGISTRAR DATE MAR 28 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

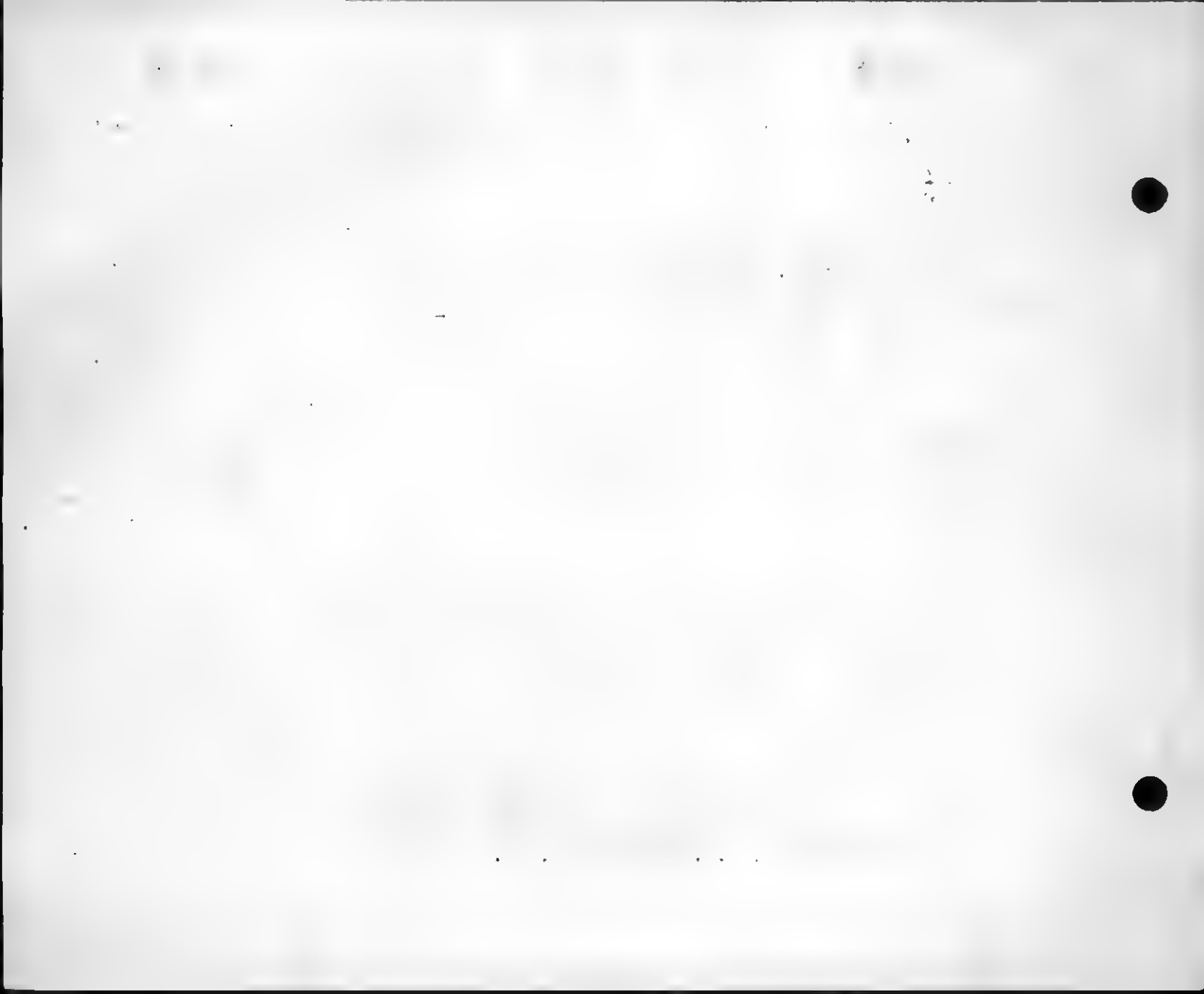
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04142

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04141

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b. DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 7300 Good Luck Road	
3 NAME OF DECEASED (Type or print) Conrad A. Schmiedicke (alias-James Afton)		4 DATE OF DEATH 3 9 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-5-1915
9 AGE (In years last birthday) 51 yrs		10 IF UNDER 1 YEAR 3 Months 9 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobiles	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Otto Schmiedicke		14 MOTHER'S MAIDEN NAME Henrietta Steinbach	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW 2,		16 SOCIAL SECURITY NO 216-09-5615	
17 INFORMANT Mrs. Henrietta Schmiedicke, Dundalk Bldg.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heartdisease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) over 1 yr. (c)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 3-9-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL CREMATION Burial (Specify)		23b. DATE THEREOF 3/13/67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.		Address	
25a. REC'D BY REGISTRAR MAR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

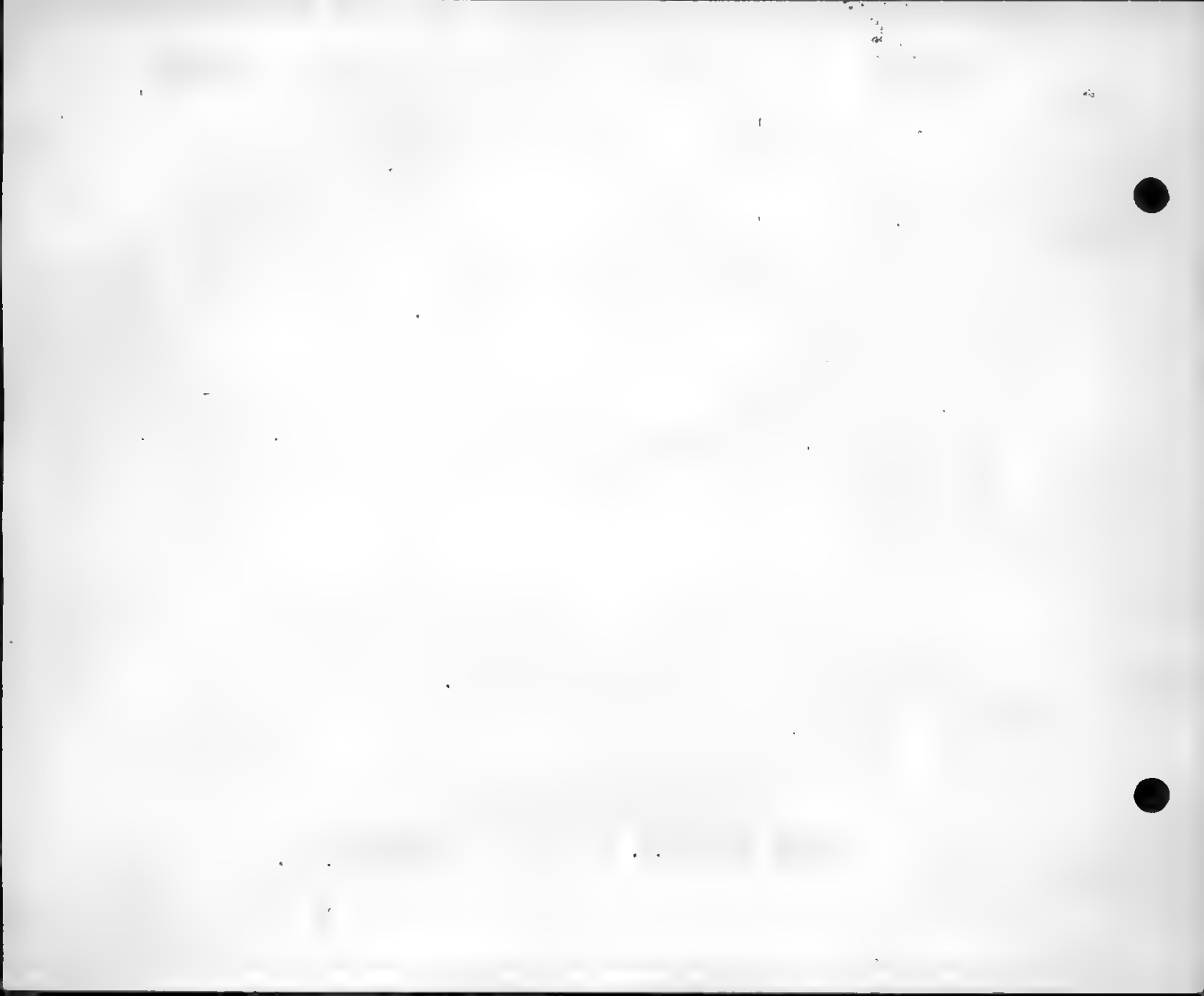
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04142

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN ID DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e STREET ADDRESS 5116 20th Avenue	
3 NAME OF DECEASED (Type or print) First Karen Middle Anne Last Schutawie		4 DATE OF DEATH Month March Day 3 Year 19 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 30 Nov. 1932
9 AGE (In years lost birthday) 34 yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months 3 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY AT HOME	
11 BIRTHPLACE (State or foreign country) ILLINOIS		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME VIRGIL GORDON		14 MOTHER'S MAIDEN NAME ERLYNNE HERRIOTT	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 579-43 1054	
17 INFORMANT MAR TED SCHUTAWIE		Address 5116 20th AVE HILLCREST HTGS MD	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 976X IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self at home.	
20c TIME OF INJURY Month, Day, Year Hour, a.m. AM p.m. 3-3-67		20d NATURE OF INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Home	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f (City or town) (County) (State) Same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-3-67	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 3-9-67	
23c NAME OF CEMETERY OR CREMATORY BEDFORD CEM		23d LOCATION (City or Town) (County) (State) REDFORD TOWA	
24 FUNERAL DIRECTOR W.W. Chambers Co.		25a REC'D BY REGISTRAR MAR 8 1967	
ADDRESS RIVERDALE, MD		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04144

CERTIFICATE OF DEATH

04143

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 6 DAYS		2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE VIRGINIA		b. COUNTY ARLINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS						d. STREET ADDRESS 1900 S. EADS ST. APT 214				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JANE PAGE SHIPP		First		Middle		Last		4. DATE OF DEATH MARCH 1 19 67		Month Day Year	
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 26 NOV 1923		9. AGE (n years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) ADAIR, KENTUCKY				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SHREVE T. DAVIS						14. MOTHER'S MAIDEN NAME KATHRYN PAGE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N/A				16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT WARREN C. SHIPP-HUSBAND-SAME AS #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANOXIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF LUNG DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 3 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 FEB 1967 , to 1 MAR 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 1 MAR 1967 , and that death occurred at 3:20M , from causes and on the date stated above.											
22a. SIGNATURE <i>Charles D. Phelps, MD</i>						P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1 MAR 67			
22c. PHYSICIAN'S NAME (Type) CHARLES D. PHELPS, CAPT, USAF, MC						22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-7-67		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl C		23d. LOCATION (City or Town) (County) (State) 78 myers Va					
24. FUNERAL DIRECTOR W.W. Chambers & 577-11-58 SE Wash DC						25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

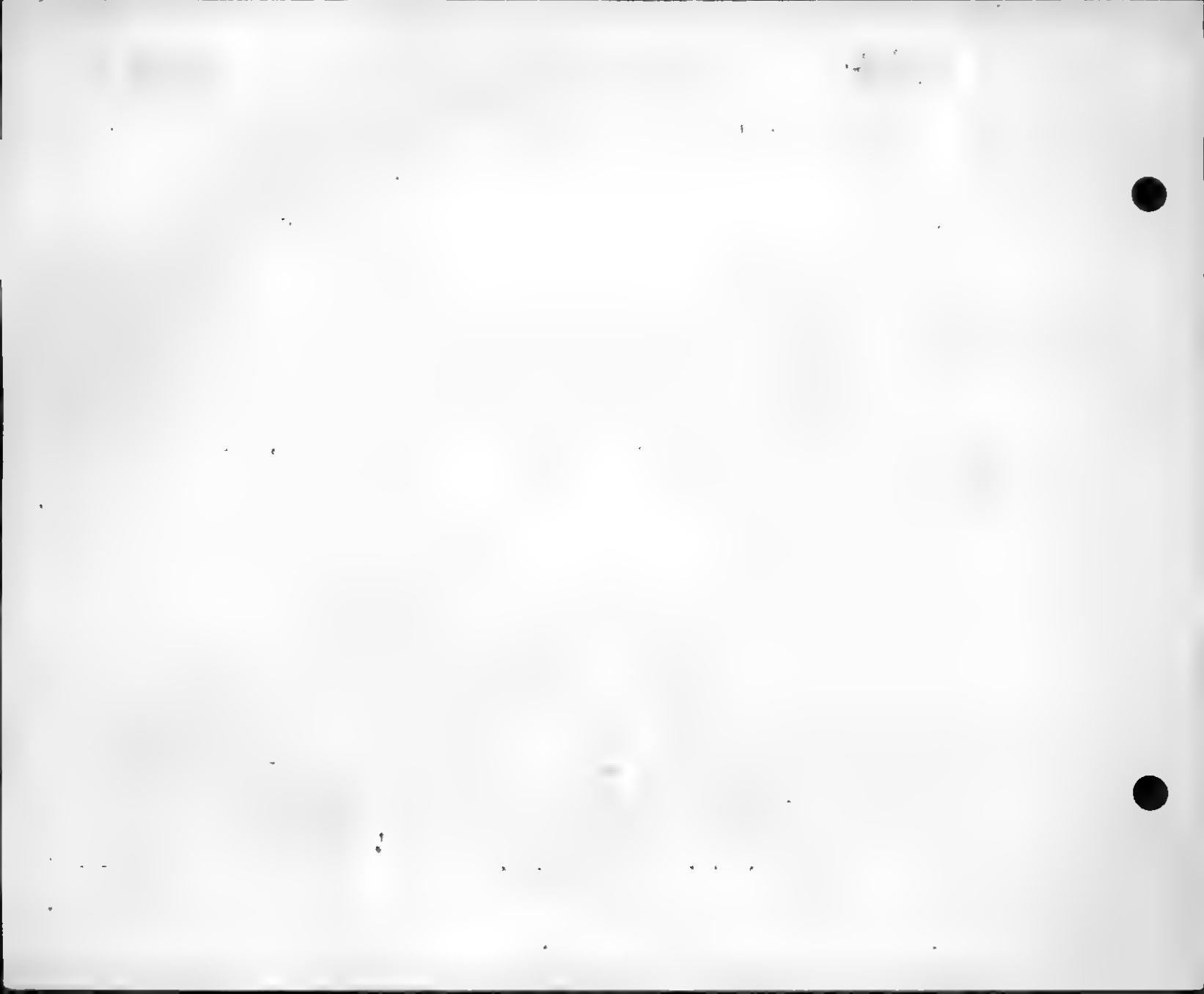
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04144

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN TB DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Fritz Juri Simon		4 DATE OF DEATH Month Day Year 3 1 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 23 April 1886
9 AGE (In years lost birthday) 80 yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Captain	
10b KIND OF BUSINESS OR INDUSTRY Merchant marines		11 BIRTHPLACE (State or foreign country) Estonia	
12 CITIZEN OF WHAT COUNTRY? U S A		13 FATHER'S NAME Unknown	
14 MOTHER'S MAIDEN NAME Unknown		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16 SOCIAL SECURITY NO. 044 12 1824		17 INFORMANT John F Simon Address Bowie, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sarcoma of liver 1561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH over 2 mo.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month Day Year Hour o.m. p.m. 19	20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22 DATE SIGNED 3-1-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a BURIAL, CREMATION, OR REMOVAL (Specify) Cremation	23b DATE THEREOF March 2, 1967	23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory	23d LOCATION (City or town) (County) (State) Solmar Manor Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons		25a REC'D BY REGISTRAR MAR 6 1967	
ADDRESS Hyattsville, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4 may be retained at the hospital or at attending physician.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

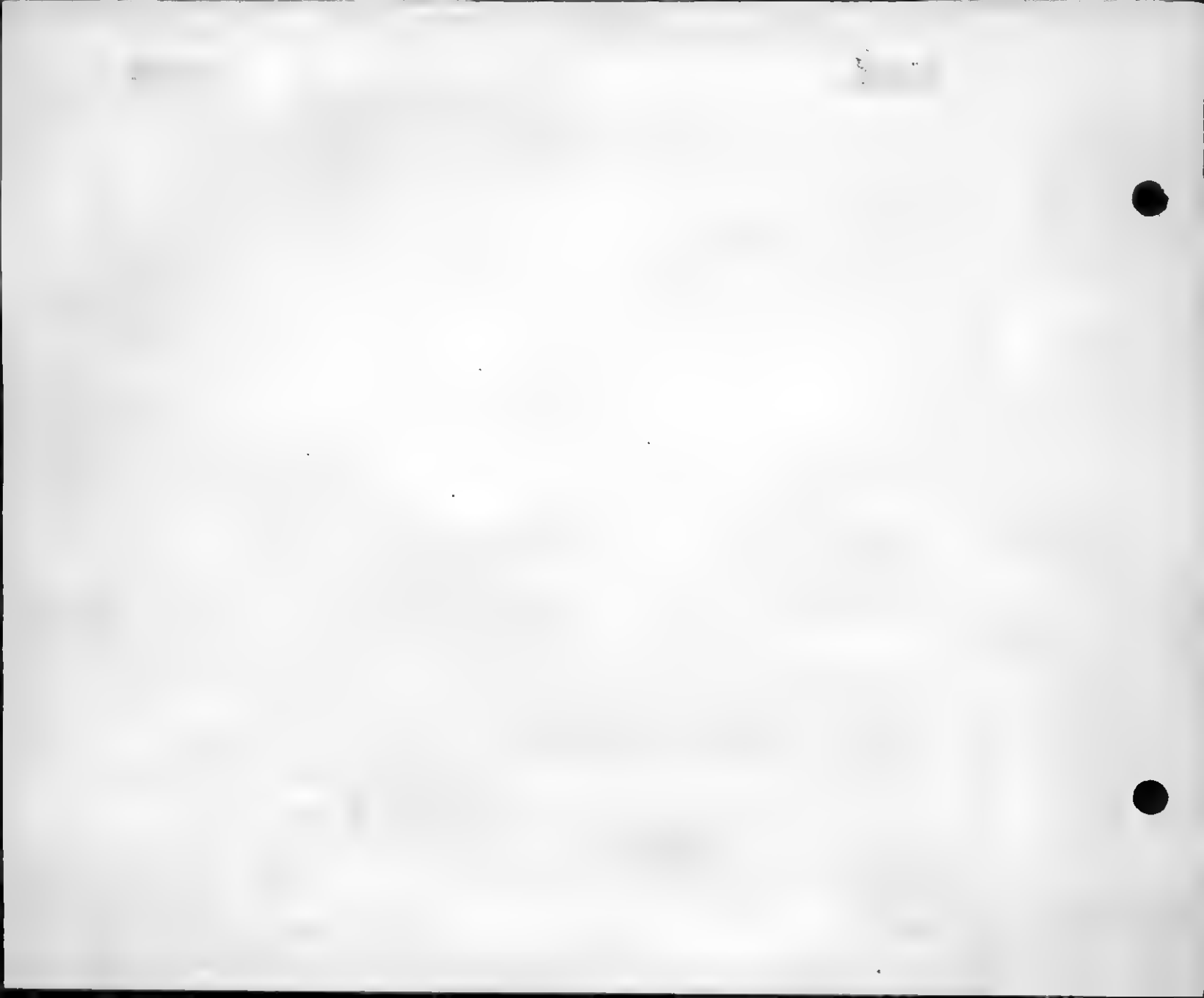
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04146

CERTIFICATE OF DEATH

04145

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Hazle, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Magnolia Gardens Nursing Home		d. STREET ADDRESS 4906-49th Ave.	
3. NAME OF DECEASED (Type or print) May Victoria Small		4. DATE OF DEATH March 3 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1876
9. AGE (In years, last birthday) 90 yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Collins		14. MOTHER'S M maiden name ? Burroughs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 578-07-0751A	
17. INFORMANT Address Mrs. Blanch L. Collins			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure			
DUE TO (b) Ventricular Tachycardia			
DUE TO (c) A.S.H. ad.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 3 P.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 3/3/67	
22c. PHYSICIAN'S NAME (Type) WILLIAM R. GRECO		22d. ADDRESS RIVERDALE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/7/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION (City or town) (County) (State) Suitland Rd. P.D. Md	
24. FUNERAL DIRECTOR WW Chambers Inc. 5555 Ga. Ave. Silver Spring, Md.		25. REC'D BY REGISTRAR DATE 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			



FOR STATE
HEALTH DEPT

04147

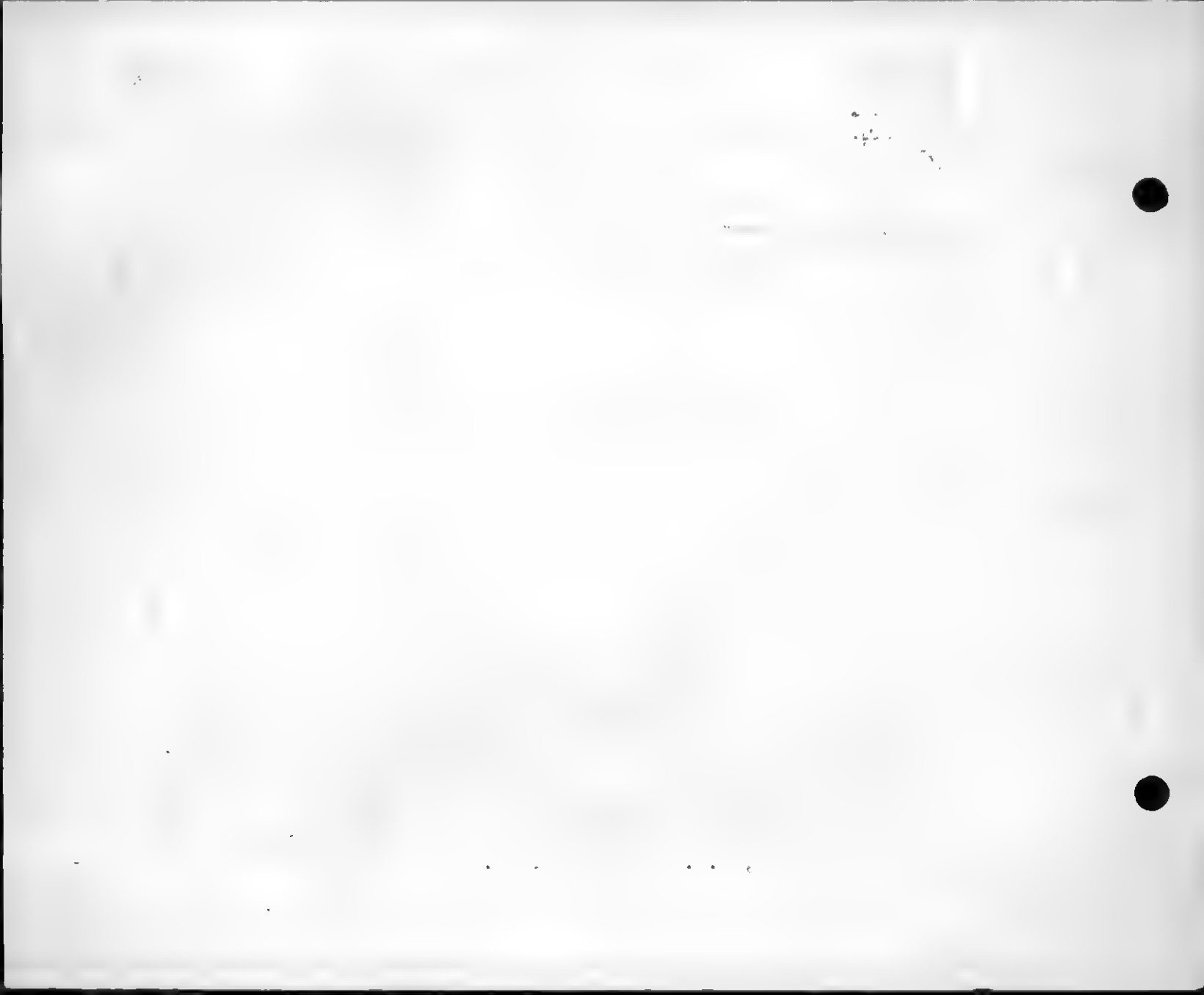
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04146

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS Box 128		
3. NAME OF DECEASED (Type or print) First Middle Last Agnes Helen Smith			4. DATE OF DEATH Month Day Year 3 8 19 67		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 July 1921	9. AGE (In years last birthday) 45 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Joshua Abrams			14. MOTHER'S MAIDEN NAME Sadie Belt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	17. INFORMANT Address Sadie Abrams - mother		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined 7755 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-9-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-11-67	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Moses Cemetery	23d. LOCATION (City or town) Arundel Co Md	(County)	(State)
24. FUNERAL DIRECTOR H.S.U. Ashington Sons		ADDRESS 4925 DENNE AVE NE		25a. REC'D BY REGISTRAR John Kehoe	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #0320 3/1/67 DC

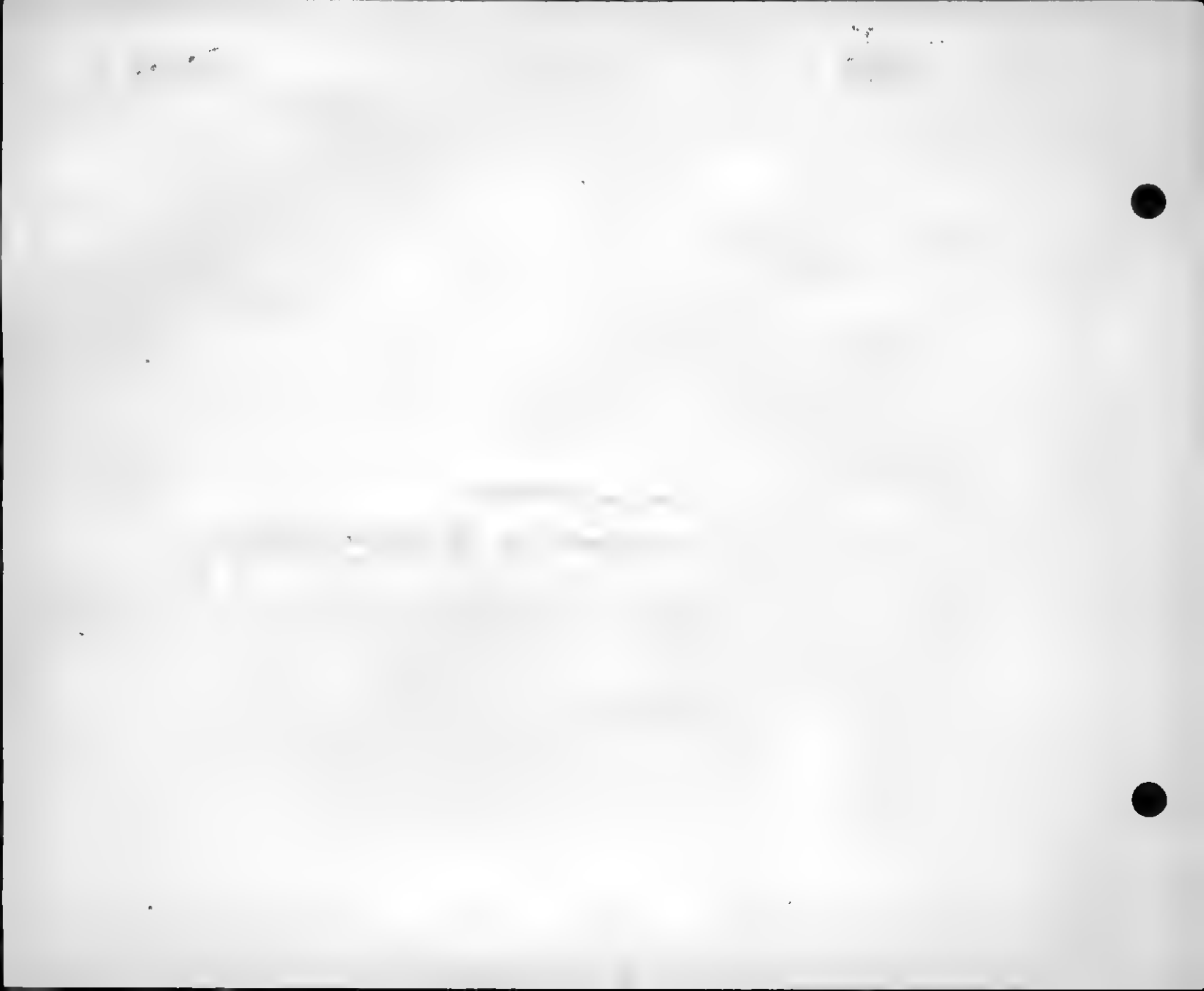
04148

CERTIFICATE OF DEATH

04147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>33 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>4310 37th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James E Smith</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 April 1918</u>		9. AGE (In years last birthday) <u>48 4/5 yrs</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	IF UNDER 24 HRS. Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles C. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Clancey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWII & Korea</u>		16. SOCIAL SECURITY NO <u>WWII & Korea</u>		17. INFORMANT <u>Florence F. Smith Same b2 wife</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Pancreas, Primary</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 1967</u> to <u>March 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 5, 1967</u> , and that death occurred at <u>7:30 AM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Benjamin A. Miller</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Benjamin A. Miller</u>				22d. ADDRESS 			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3-9-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>at Olivet Cemetery</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300-4th St. N.L.</u>				25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

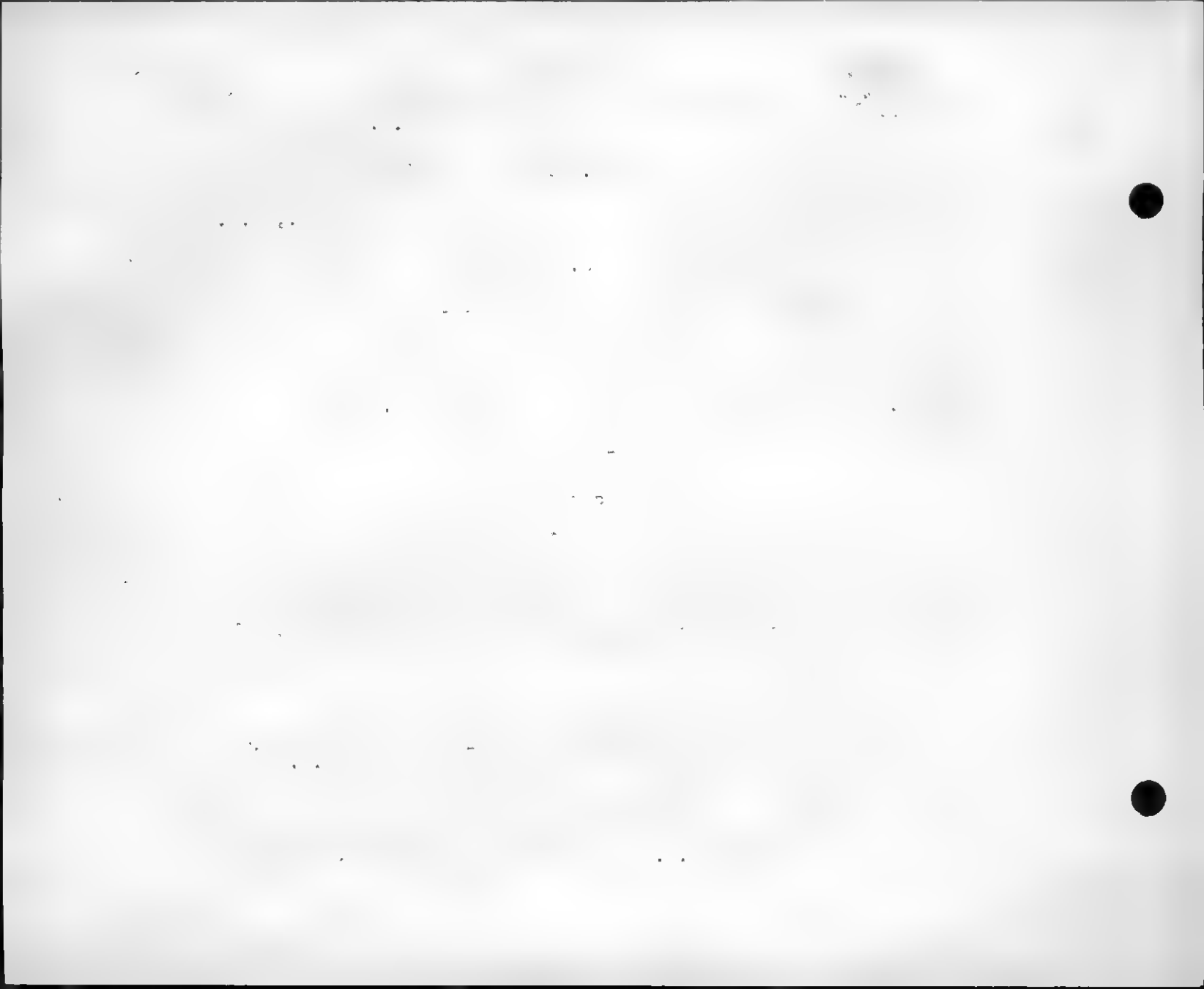
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04149

CERTIFICATE OF DEATH

04148

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 2 mo. 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 1512 Marion St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lorraine Middle J. Last Smith			4. DATE OF DEATH Month March Day 25 Year 19 67				
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-7-1913		9. AGE (In years last birthday) 54 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Hubbert			14. MOTHER'S MAIDEN NAME Lillie M. Mason				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 577-26-9779		17. INFORMANT Decedent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Arteriosclerotic heart disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						INTERVAL BETWEEN ONSET AND DEATH 24 hours unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis; chronic alcoholism with Laennec cirrhosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)		
21. I certify that (a) (this hospital) attended the deceased from 1--4--67 to 3-25 , 19 67 that (b) (we) last saw the deceased alive on 3-25 , 19 67 , and that death occurred at 12:30 A.M. from causes and on the date stated above							
22a. SIGNATURE <i>Moe Weiss</i>			M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.			22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland				
23a. (BURIAL) CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Mar. 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		23d. LOCATION (City or Town) (County) (State) Lanham Md.			
24. FUNERAL DIRECTOR <i>Travis Funeral Home</i>		ADDRESS 389 P.T. Ave., NW		25a. REC'D BY REGISTRAR MAR 29 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04150

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04149

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Wilbur A Smith				4 DATE OF DEATH Month Day Year 3 26 19 67			
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 15 June 1907	
9 AGE (In years last birthday) 59 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAXI CAB DRIVER		10b. KIND OF BUSINESS OR INDUSTRY DIAMOND CAB CO.		11 BIRTHPLACE (State or foreign country) WASHINGTON D.C.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.				13 FATHER'S NAME HARTWELL D. SMITH			
14 MOTHER'S MAIDEN NAME UNKNOWN				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES PEACE TIME			
16 SOCIAL SECURITY NO —				17 INFORMANT MRS. BERTHA F. SMITH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) over 2 yrs.				INTERVAL BETWEEN ONSET AND DEATH minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
22. DATE SIGNED 3-27-67				23. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD.				25. REC'D BY REGISTRAR MAR 29 1967			
26. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.				27. LOCATION (City or town) (County) (State) BLADENSBURG, MD.			

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City or town)

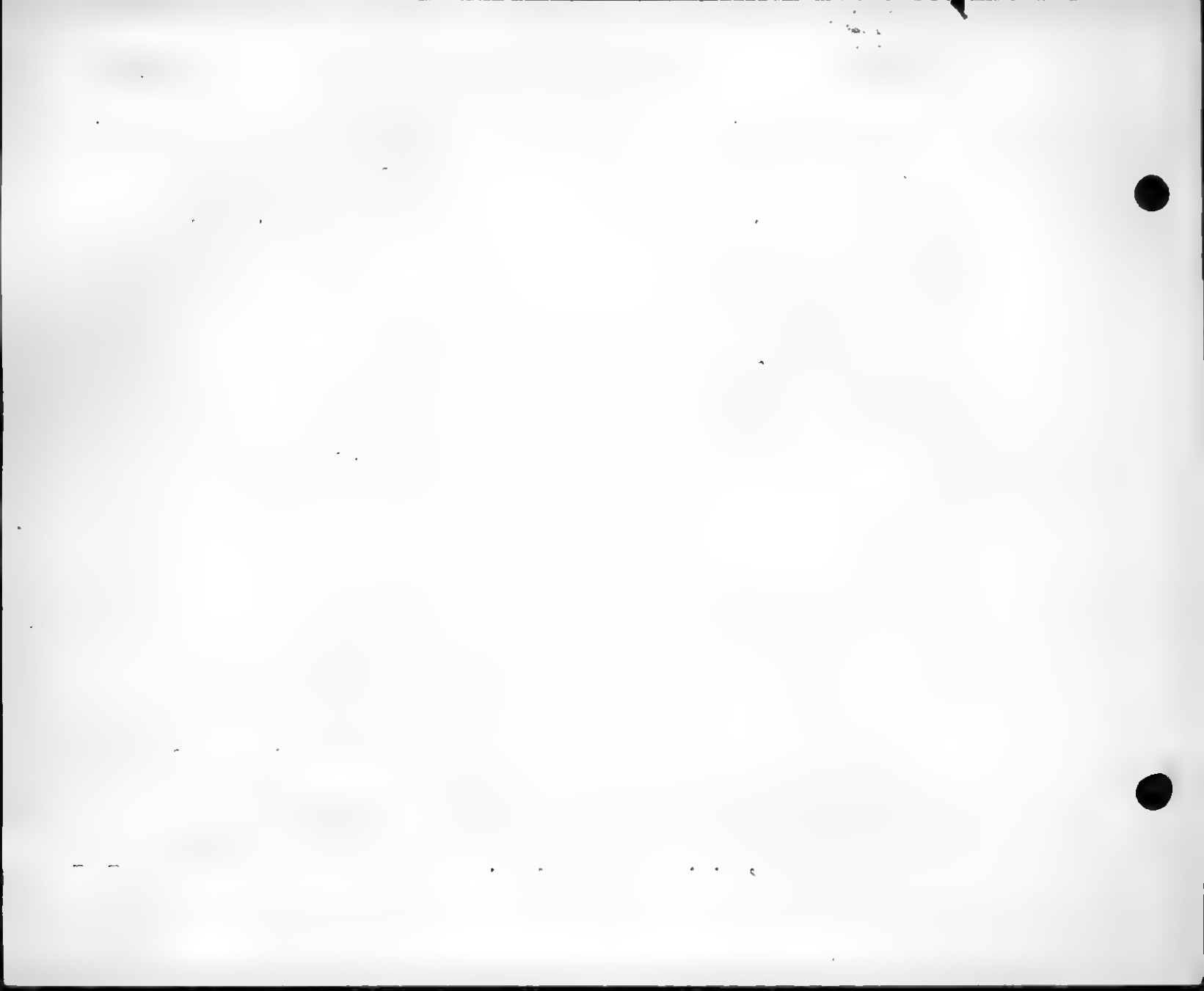
(County) (State)

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

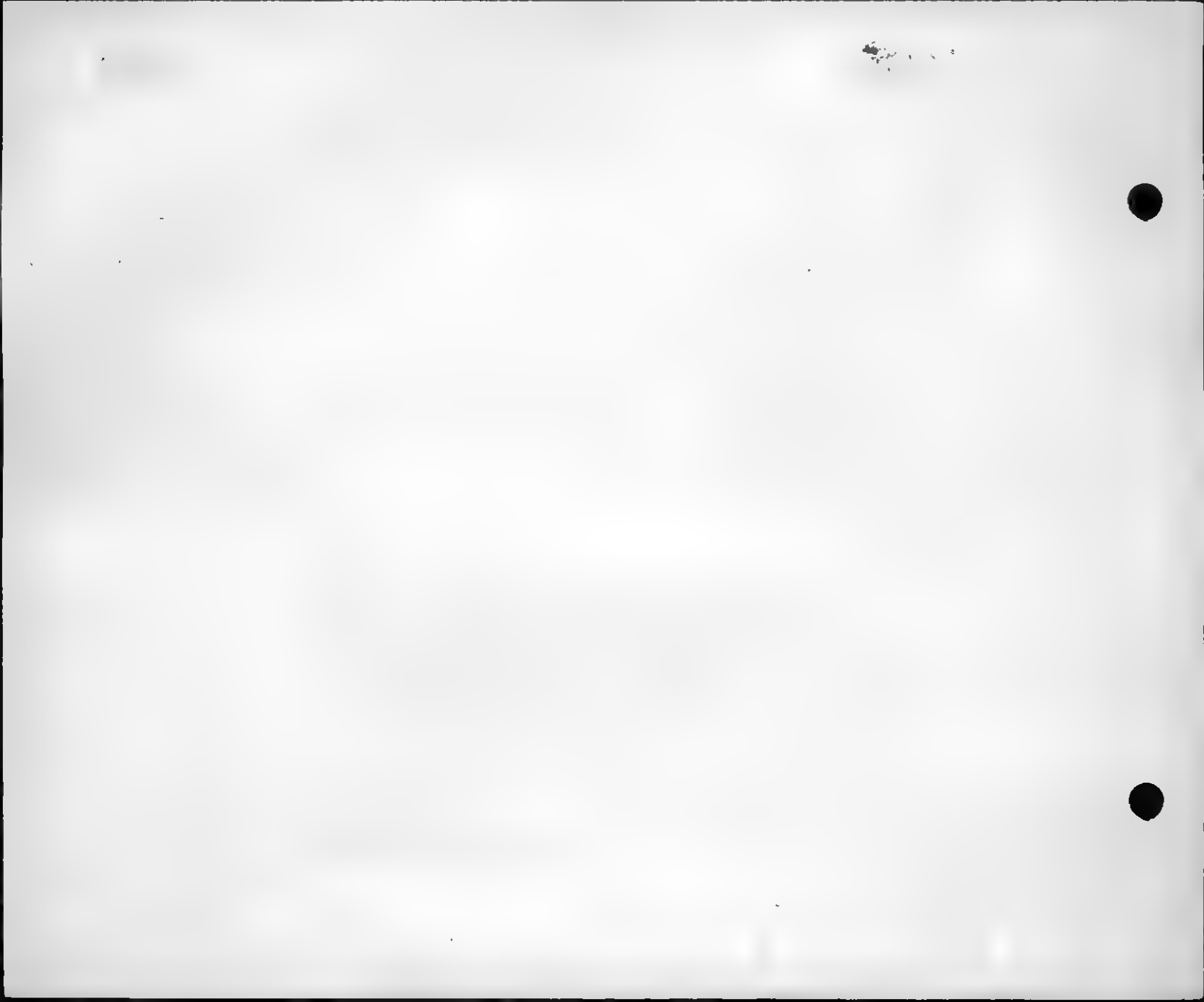
04151

CERTIFICATE OF DEATH

04150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission a. STATE <u>NONE</u> b. COUNTY <u>NONE</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DISTRICT HGTS</u>		c. LENGTH OF STAY IN TB <u>3 MONTHS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u> 413		d. STREET ADDRESS <u>3039- QUE ST NW.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>REGENT NURSING HOME - 8100 MARLBORO</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>A.D.A.</u> Middle <u>C.</u> Last <u>SMOOT</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 17, 1895</u> 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u>
13. FATHER'S NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO <u>577-07-18632</u>	
17. INFORMANT <u>LEORA M. PENNYPACKER</u>		Address <u>3039-QUE ST NW.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>in coronary embolism</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Thromboembolism of brain and heart</u> DUE TO (c) <u>Fractured hip in Piro</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.H.F.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-13-</u> , 19 <u>67</u> , to <u>3-17-</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>3-17</u> , 19 <u>67</u> , and that death occurred at <u>11:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>MARK H. PILLOR MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>3-17-67</u>
22c. PHYSICIAN'S NAME (Type) <u>MARK H. PILLOR MD</u>		22d. ADDRESS <u>7505 AVON CT, WASH. DC 31</u>	
23a. BURIAL, CREMATION, or MOVING (Specify)	23b. DATE THEREOF <u>3/27/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>	23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VA.</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co -</u>		ADDRESS <u>WASHINGTON, D.C.</u>	25a. REC'D BY REGISTRAR <u>MAR 20 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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1

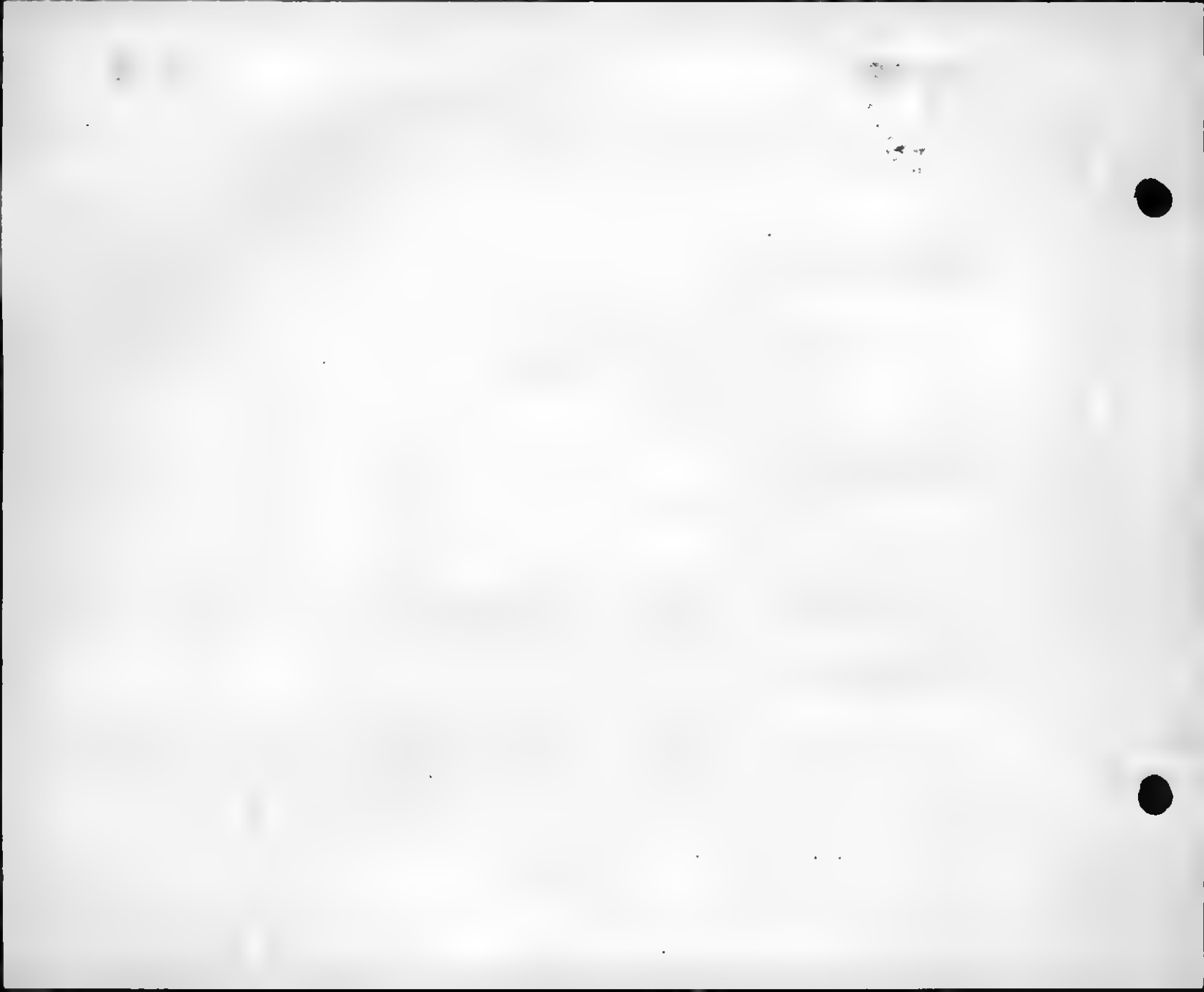
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04152

CERTIFICATE OF DEATH

04151

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN TB <u>2 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Island Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>INFANT</u> <u>SOUTHARD</u>		4. DATE OF DEATH Month Day Year <u>3</u> <u>30</u> <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none CHILD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>0</u> yrs. IF UNDER 1 YEAR Months Days Hours Min <u>0</u> <u>2</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Prince Georges co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Donald Thomas Southard</u>		14. MOTHER'S MAIDEN NAME <u>Collette Gilberte Langis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>MR RAYMOND LANGIS</u>		Address <u>5109 70th PL HYATTSVILLE, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anencephaly</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> , 1967, to <u>3-31</u> , 1967, that (I) (we) last saw the deceased alive on <u>3-30</u> , 1967, and that death occurred at <u>3:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D. R. Purdie</u>		22b. DATE SIGNED <u>3-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. R. PURDIE, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-31-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	23d. LOCATION (City or Town) (County) (State) <u>WHEATON MARYLAND.</u>
24. FUNERAL DIRECTOR <u>W. W. Chamberlain</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

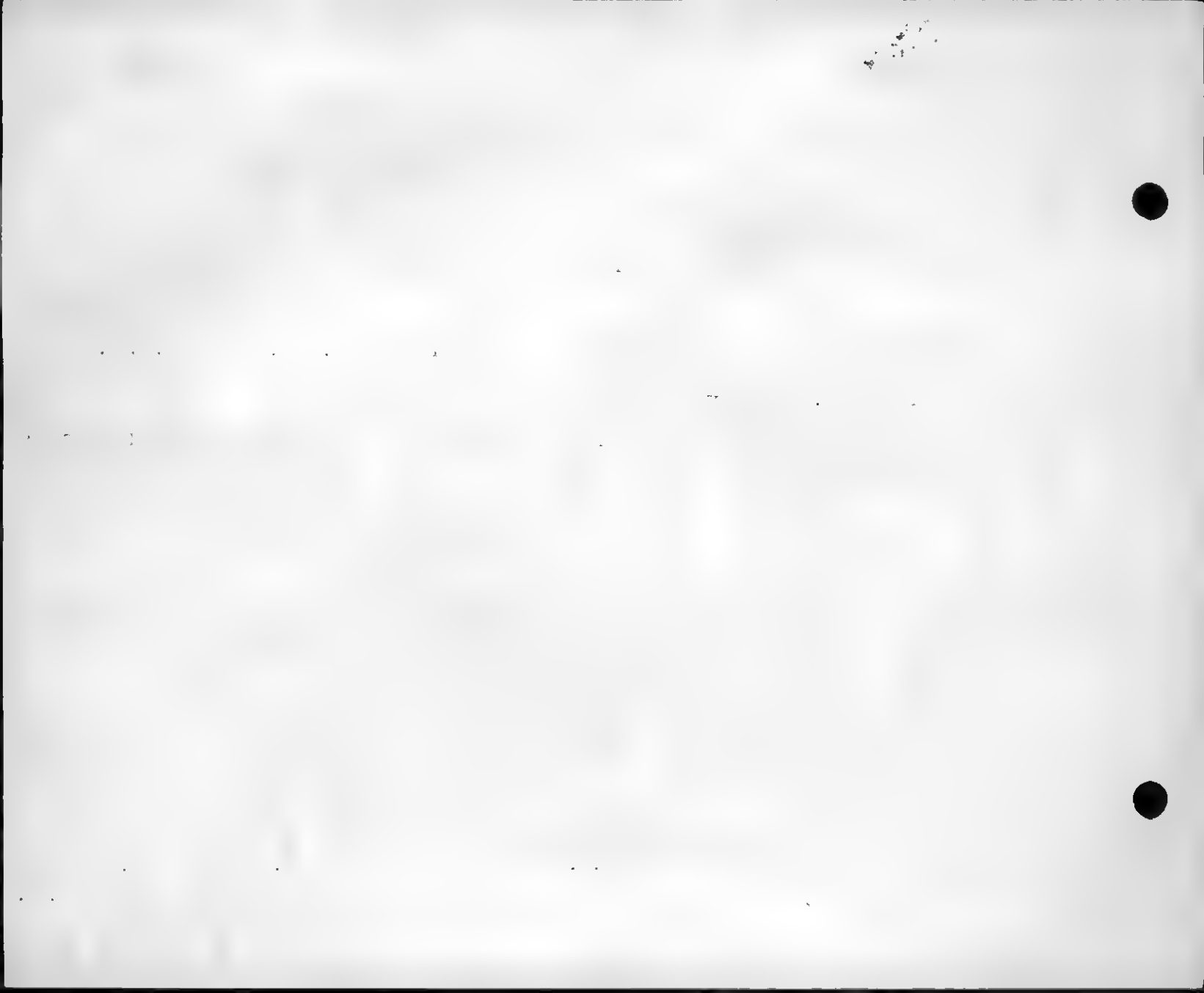
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04153

CERTIFICATE OF DEATH

04152

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3611 Cooper Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Elvia Renfrow Stokes First Middle Last		4. DATE OF DEATH March 10, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/09
9. AGE (in years lost birthday) 57 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Johnston Co., N. C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William H. Renfrow		14. MOTHER'S MAIDEN NAME Luria Stancil	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 578 42 4306	
17. INFORMANT James David Stokes		Address Same as #2 (husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, ACUTE 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 1959, to 3/10 , 1967, that (I) (we) last saw the deceased alive on 3/10 , 1967, and that death occurred at 1:45 A.M., from causes and on the date stated above			
22a. SIGNATURE Norman Donat Comeau M.D.		22b. DATE SIGNED 3/10/67	
22c. PHYSICIAN'S NAME (Type) Norman Donat Comeau, M.D.		22d. ADDRESS 3503 Perry St., Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13/67	23c. NAME OF CEMETERY OR CREMATORY Stancil Church Cemetery	23d. LOCATION (City or Town) (County) (State) Kenley Johnston N.C.
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04154

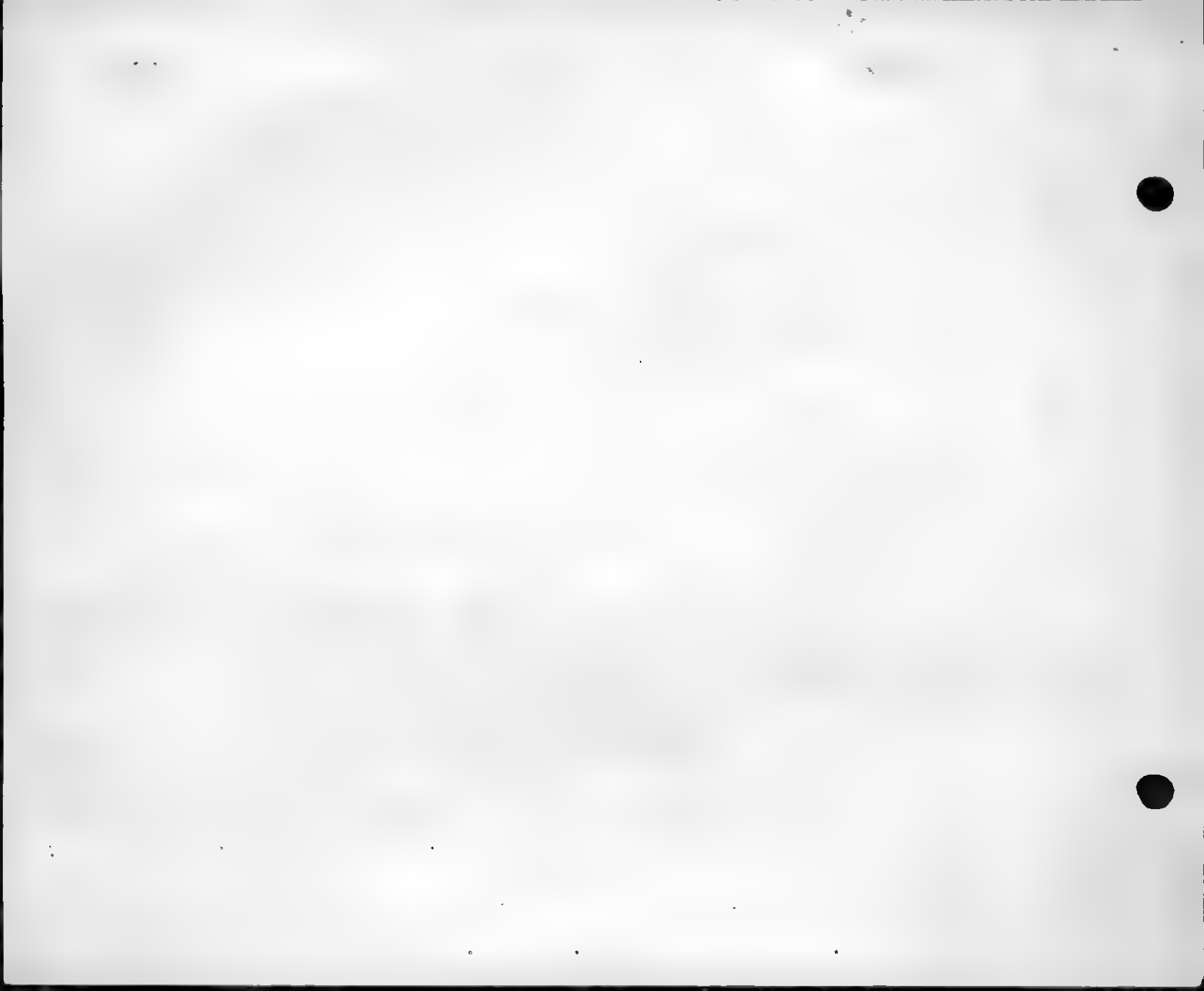
CERTIFICATE OF DEATH

04153

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN 1b 6 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suitland Nursing Home Suitland Md		d. STREET ADDRESS 7209 Coolridge Rd. 2001	
3 NAME OF DECEASED (Type or print) Pessie S. Tolbert		4 DATE OF DEATH March 13 19 67	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct 19, 1888
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Judge		14. MOTHER'S MAIDEN NAME Lena Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Darnel Tolbert		Address 7209 Coolridge Rd. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Anterior wall MI DUE TO (c) Anterior wall MI Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Mar 11, 1966 to 3/13/67, that (I) (we) last saw the deceased alive on 3/11/67, 1967, and that death occurred at 10:15 PM, from causes and on the date stated above.			
22a. SIGNATURE J. N. Thibodeau		22b. DATE SIGNED 14 MAR 1967	
22c. PHYSICIAN'S NAME (Type) Dr. J. N. Thibodeau		22d. ADDRESS 3115 Alabama Ave., S.E. Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 16-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Simmons Bros. Funeral Home 1661-Gd. Hope Rd. SE		25a. REC'D BY REGISTRAR MAR 15 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

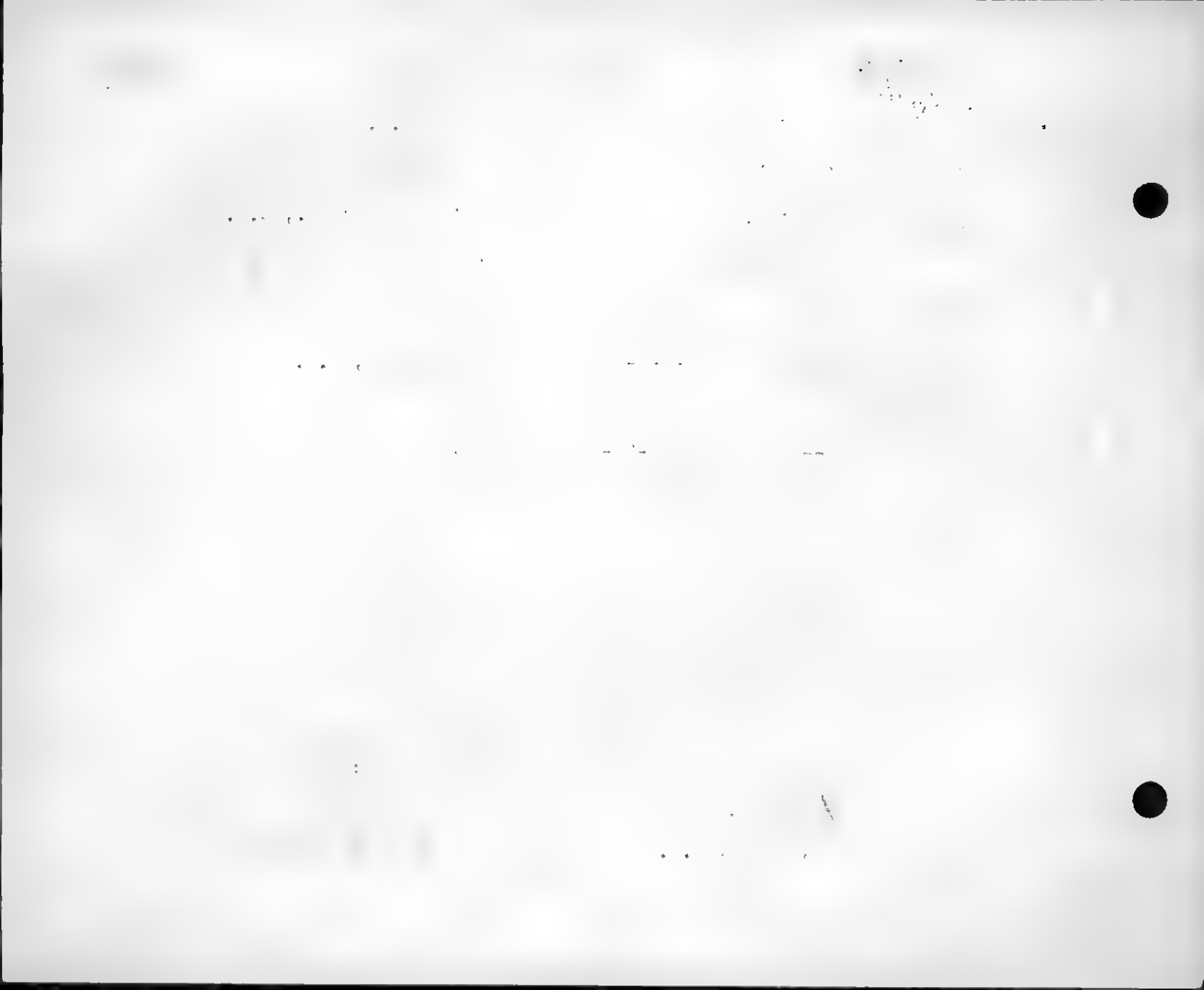
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04155

CERTIFICATE OF DEATH

04154

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 4 mos 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Leroy Tarlton		4. DATE OF DEATH Month Day Year March 11 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/1910
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joe Tarlton		14. MOTHER'S MAIDEN NAME Louise Sims	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No ---		16. SOCIAL SECURITY NO. 578-24-8964	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma, right lung, with general- ized metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchial biopsies 11/4/66 and 11/14/66		INTERVAL BETWEEN ONSET AND DEATH 4 mo.	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 10/25 , 19 66 , to 3/11 , 19 67 , that (we) lost saw the deceased alive on 3/11 , 19 67 , and that death occurred at 6:25P M, from causes on and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 3/11/67	
22c. PHYSICIAN'S NAME (Type) Moe, Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/17/67	23c. NAME OF CEMETERY OR CREMATORY St. Paul Methodist	23d. LOCATION (City or Town) (County) (State) Oxon Hill, Md.
24. FUNERAL DIRECTOR ROBERT G. MOSEN FUN. HOME		25a. REC'D BY REGISTRAR SE MAR 17 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

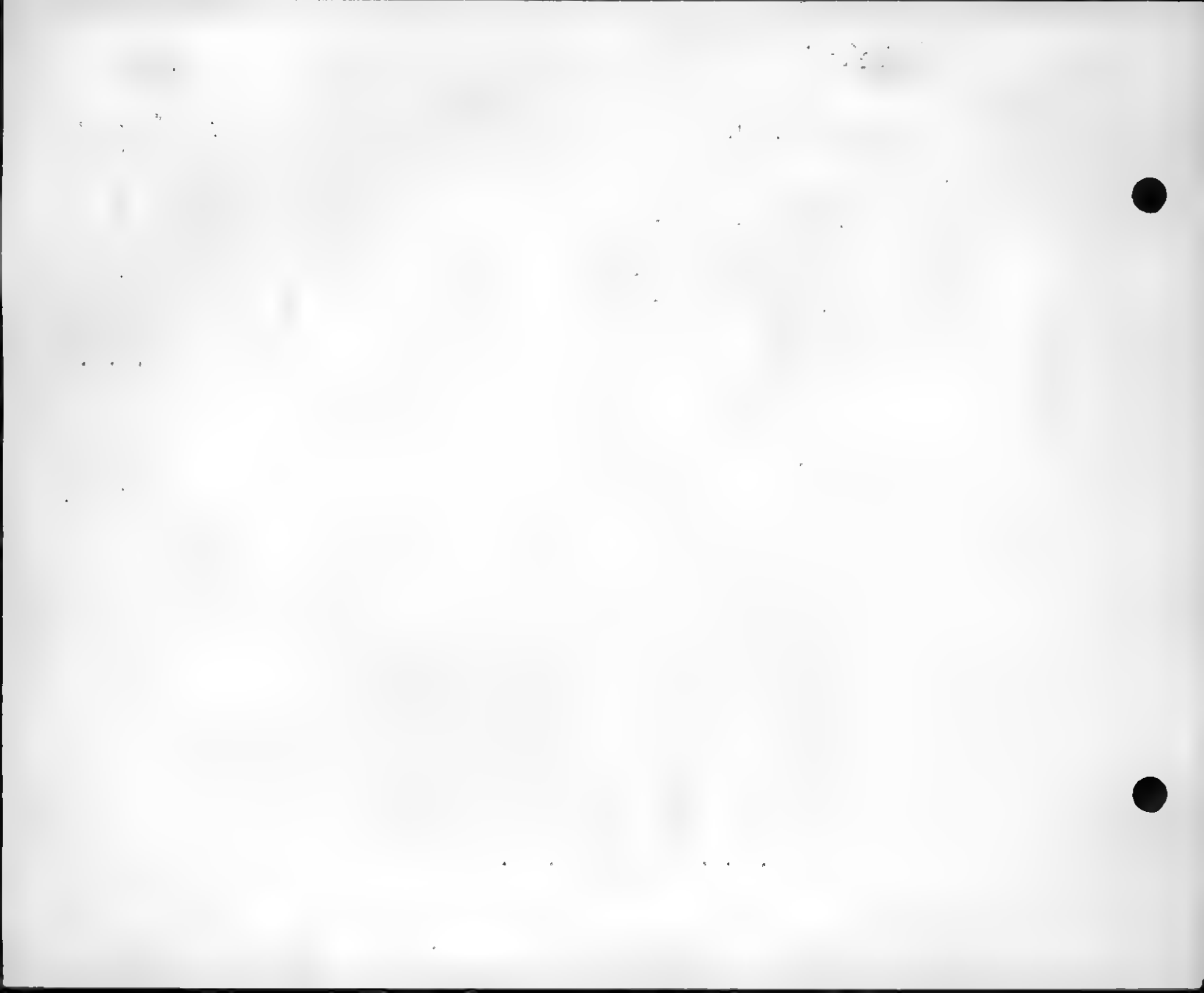
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04156

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04155

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY N to Ib DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 6210 Shadyside Avenue			
3 NAME OF DECEASED (Type or print) First Middle Last Horace Stanley Taylor				4 DATE OF DEATH Month Day Year 3 8 1967			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH 9-1-1901	9 AGE (n years lost birthday) 65 yrs	F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a US. OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Goldthwaite, Kansas	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16 SOC. A. SECURITY NO. 579-32-5763		17 INFORMANT Inez W. Taylor Address Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 3-8-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-11-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or town) (County) (State) Suitland, Maryland	
24. SIGNATURE OF REGISTRAR Robert A. Mattingly				25a. REC'D BY REGISTRAR MAR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04157		04156	
1. PLACE OF DEATH a. COUNTY <u>Prince George Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp Springs</u>	
c. LENGTH OF STAY IN 1b <u>2-17-67</u>		d. STREET ADDRESS <u>6621 Pots Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pineview Gardens Health Care Center</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTER O</u> Middle <u>TAYLOR</u> Last <u>TAYLOR</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-3-1886</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rockingham Co. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wm. Franklin Taylor</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Ross</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO <u>281-18-1514</u>		17. INFORMANT <u>Arthur Taylor</u> Address <u>Camp Springs Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>vascular collapse</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>anemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>12</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> , 19 <u>67</u> to <u>3-6</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-6</u> , 19 <u>67</u> and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Capin</u> M.D.		22b. DATE SIGNED <u>3/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. CAPIN</u>		22d. ADDRESS <u>QUINTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/9/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carman Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Gomer Ohio</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home, Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>MAR 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

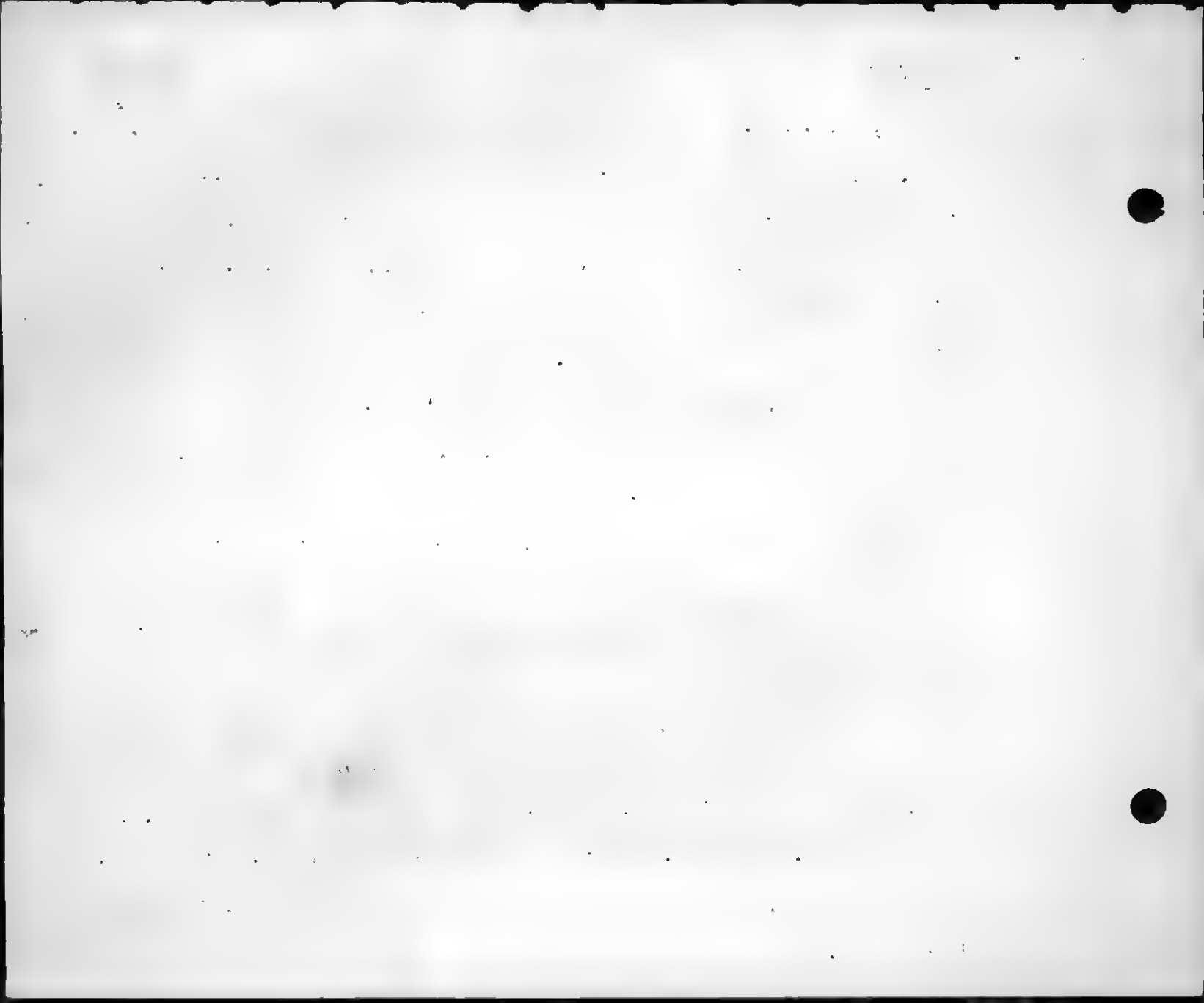
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04158

CERTIFICATE OF DEATH

04157

1. PLACE OF DEATH a. COUNTY Pr. Geo.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5506--Old Branch Ave., Camp Springs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 5506--Old Branch Ave., SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM		Middle A.		Last TAYLOR Sr.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 15-1904		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Cutter Briggs Meat Co.		10b. KIND OF BUSINESS OR INDUSTRY Briggs Meat Co.		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Julian H. Taylor		14. MOTHER'S MAIDEN NAME Lillie Mae Jenkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 579 01 9057		17. INFORMANT Doris G. Taylor (Wife) Same as Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 3561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AMYOTROPIC LATERAL SCLEROSIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>3/29</u> , 19 <u>67</u> to <u>3/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> , 19 <u>67</u> , and that death occurred at <u>10:15</u> AM, from the causes and on the date stated above.					
22a. SIGNATURE <u>Norman D. Comeau</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Mar. 28-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Norman D. Comeau		22d. ADDRESS 3503--Perry St., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 31-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City, town or county) (State) Suitland, Maryland					
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		ADDRESS Simmons Bros. 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR MAR 29 1967	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

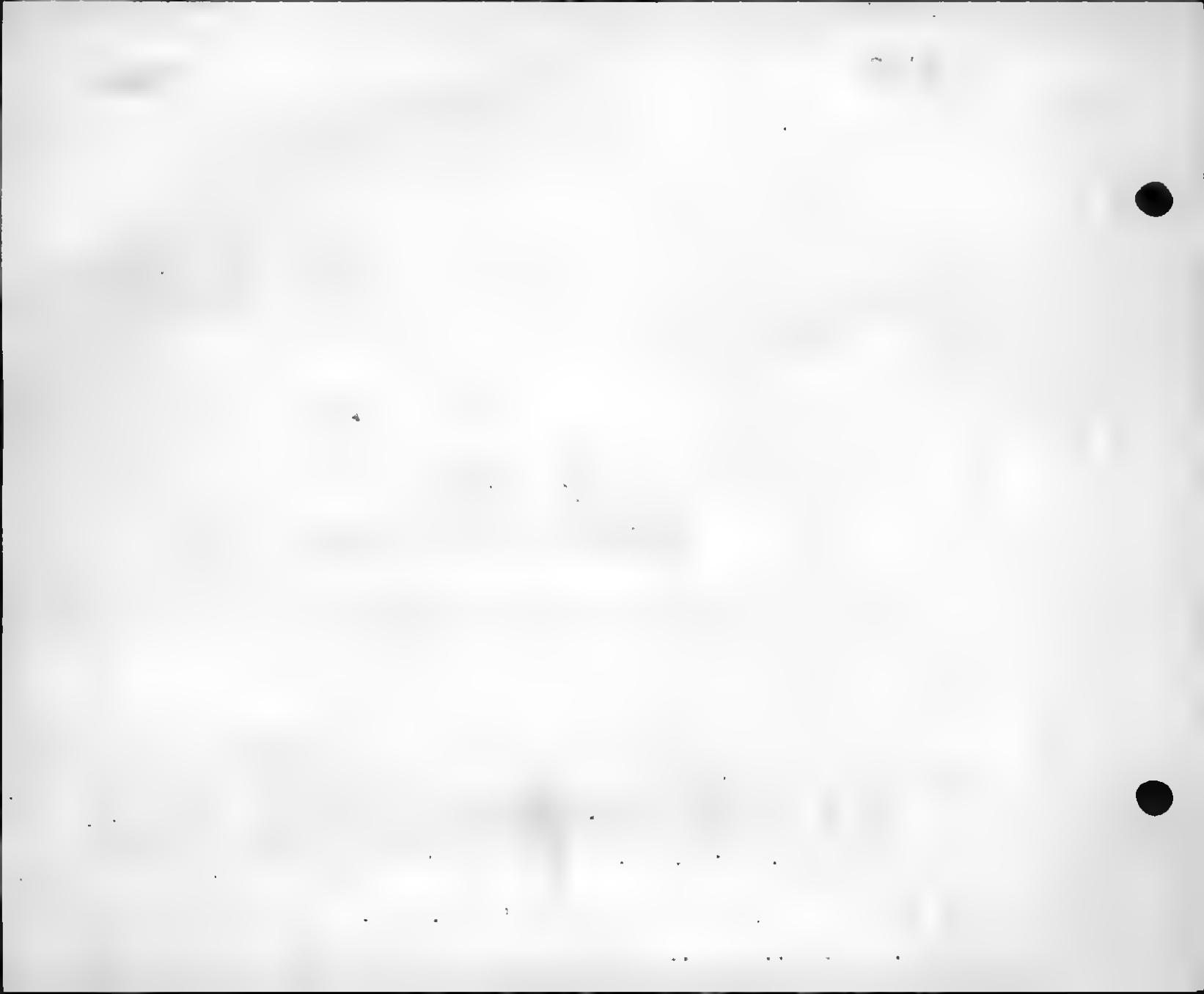
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04159

CERTIFICATE OF DEATH

04158

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 4 hr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5405 Detroit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Thomas				4. DATE OF DEATH Month Day Year 28 March 12 1967			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 March 1967		9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR Months Days Hours Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Hollie Thomas				14. MOTHER'S MAIDEN NAME Ramona Elizabeth Green			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Atherosclerosis DUE TO Prematurity (1200 gms) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from March 12, 1967 , to March 12, 1967 , that (I) (we) last saw the deceased alive on March 12, 1967 , and that death occurred at 7:15 AM , from causes and on the date stated above.							
22a. SIGNATURE Andrew G. Aronfy				22b. DATE SIGNED March 14, 1967		22c. PHYSICIAN'S NAME (Type) Andrew G. Aronfy, M.D.	
22d. ADDRESS Prince Georges General Hospital, Cheverly				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/25/67		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen Hosp		23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland				25a. REC'D BY REGISTRAR MAR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04160

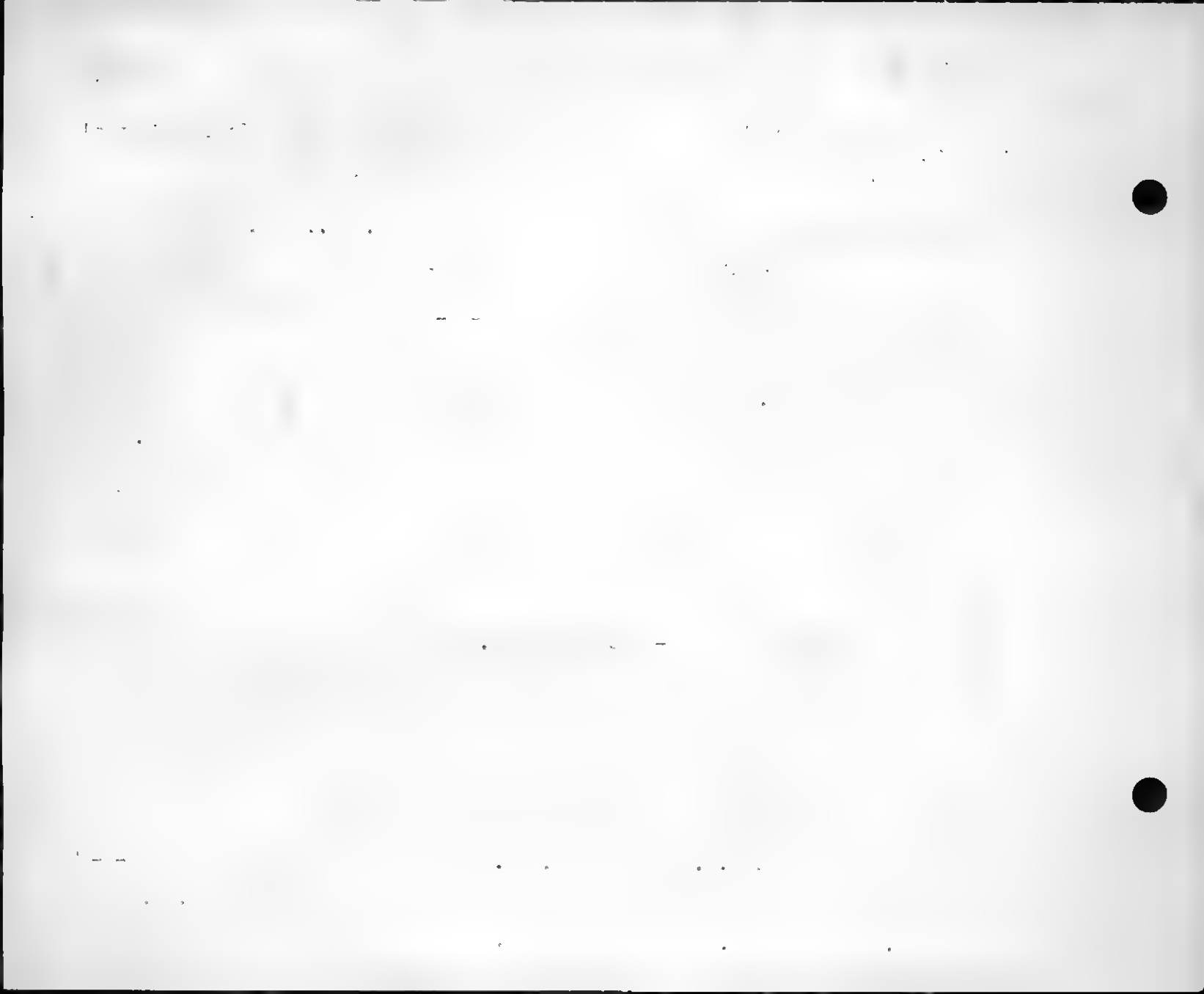
04159

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived) f institution Residence before admission a STATE Maryland b COUNTY Prince George's		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d STREET ADDRESS All 751st. St., Apt. 101		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Earnest Joseph Thomas			4 DATE OF DEATH Month Day Year 3 2 19 67		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9-24-1904	9 AGE (in years last birthday) yrs 62	10 UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b KIND OF BUSINESS OR INDUSTRY College		11 BIRTHPLACE (State or foreign country) Washington D C	
13. FATHER'S NAME William G. Thomas			14. MOTHER'S MAIDEN NAME Resina Wege		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOC. A. SECURITY NO 578 12 2403		17. INFORMANT Maude V Thomas Address Bladensburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes unknown					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema - over 10 years.					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington D. C.	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 3-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		ASSISTANT MED. CA. EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL/CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF March 6, 1967		23c NAME OF CEMETERY OR CREMATOR Prospect Hill Cemetery	
24 FUNERAL DIRECTOR F. Gasch's Sons.		ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR DATE MAR 6 1967	
				25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

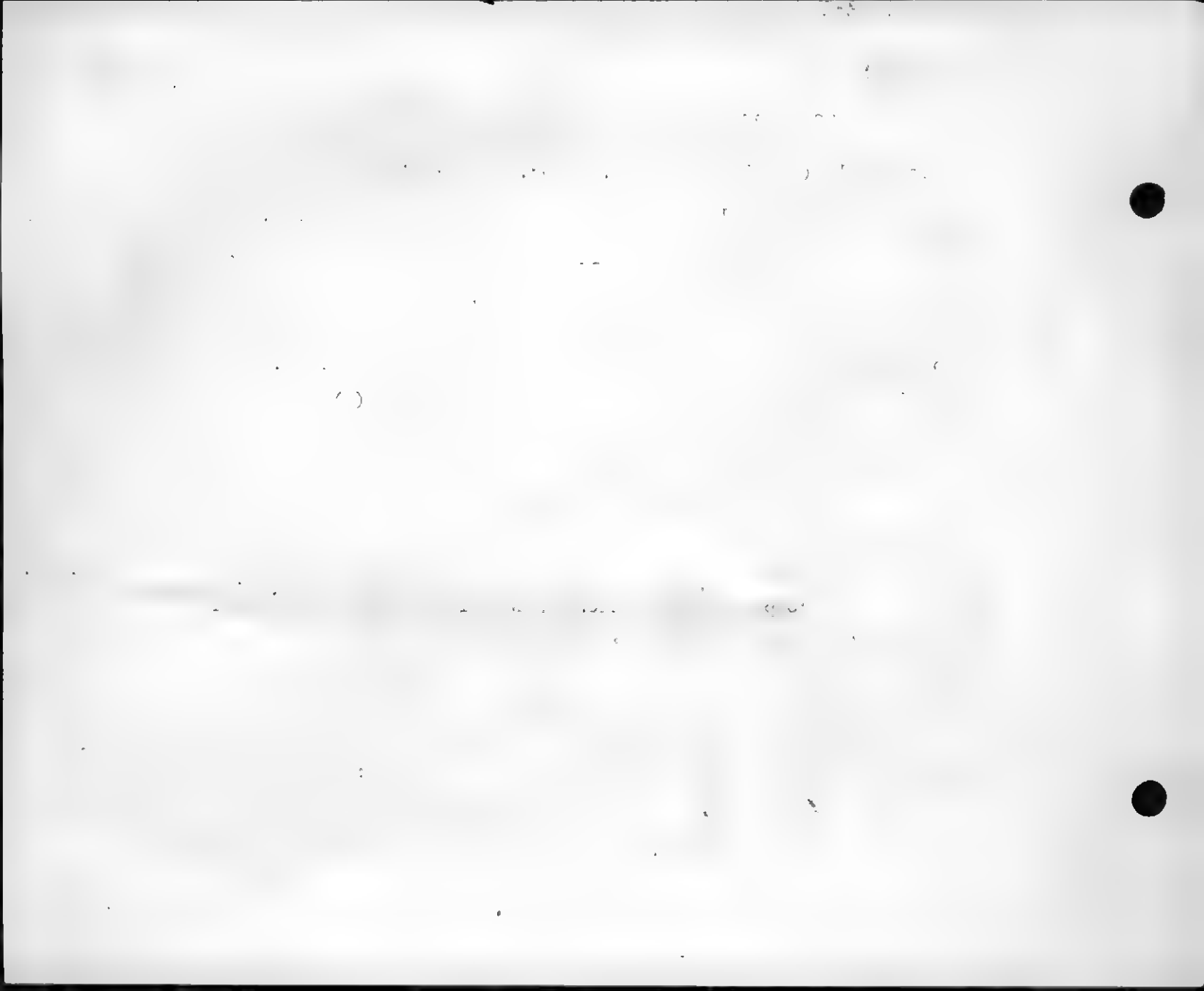
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04161

CERTIFICATE OF DEATH

04160

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1 yr., 4 mos.		d. STREET ADDRESS 1510 P St., N. W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Jennie Middle -- Last Thomas		4 DATE OF DEATH Month 3 Day 8 Year 19 67	
5. SEX F	6 COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/7/1900
9 AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Halls Hills, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Webster		14. MOTHER'S MAIDEN NAME Alice (?)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 555X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) -- DUE TO (c) Cyst of liver, etiology undetermined, with practically complete destruction of the right lobe of the liver		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT REQUIRED TO THE FORMAL STATE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis; rheumatoid arthritis		19. WAS A TUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 11/3/ , 19 65 , to 3/8/ , 19 67 , that (X) (we) last saw the deceased alive on 3/8/ , 19 67 , and that death occurred at 2:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 3/8/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/16/67	23b. DATE THEREOF 3/16/67	23c. NAME OF CEMETERY OR CREMATORY HARMONY	23d. LOCATION (City or Town) (County) (State) MARYLAND
24. FUNERAL DIRECTOR UNIVERSAL F.H.S. 16 H. STONE		25a. REC'D BY REGISTRAR MAR 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #11 info. taken from birth cert. pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

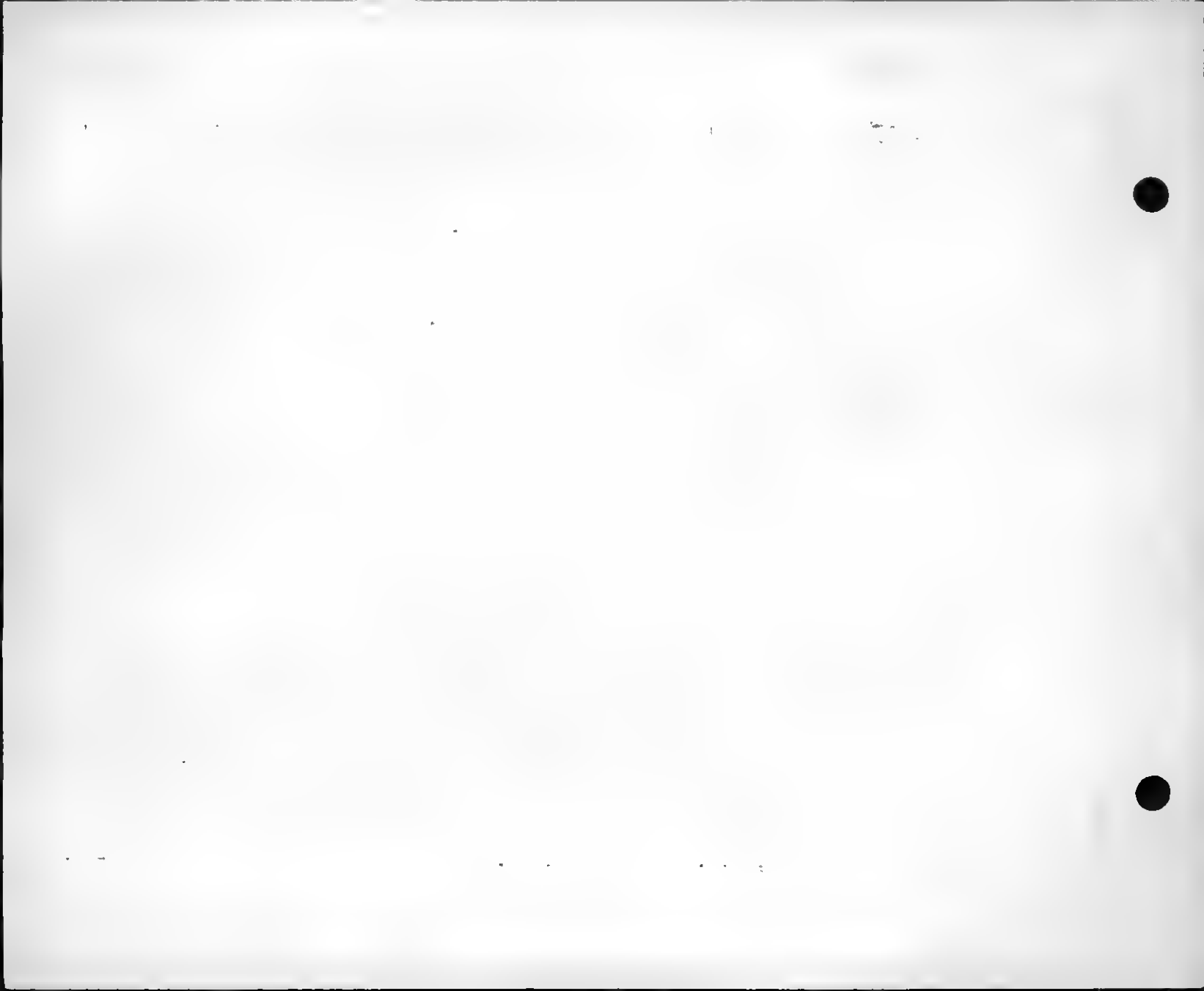
04162

04161

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d STREET ADDRESS Brandywine Rt. 1, Box 167			
3 NAME OF DECEASED (Type or print) Shirley Diane Thomas				4 DATE OF DEATH 3 25 19 67			
5 SEX Female		6 COLOR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 10 Nov. 1966	
9 AGE (in years lost birthday) yrs 4		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Cheverly, Pr. Geo. Co.	
13 FATHER'S NAME Albert Leroy Johnson				14 MOTHER'S MAIDEN NAME Bernice G. Thomas			
15 WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT Address Bernice Thomas - Rt. 1 - Box 167 Brandywine Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Undetermined 7105 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last SDII DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 3-26-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a BURIAL, CREMATION, or other disposal Burial		23b DATE THEREOF 3-28-67		23c NAME OF CEMETERY OR CREMATORY Church of God - Cemetery		23d LOCATION (City or town) (County) (State) Brandywine Pr. Geo. Md.	
24. FUNERAL DIRECTOR Marshall Adams Aquasco, Md.				25a RECEIVED BY REGISTRAR APR 6 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M - 67

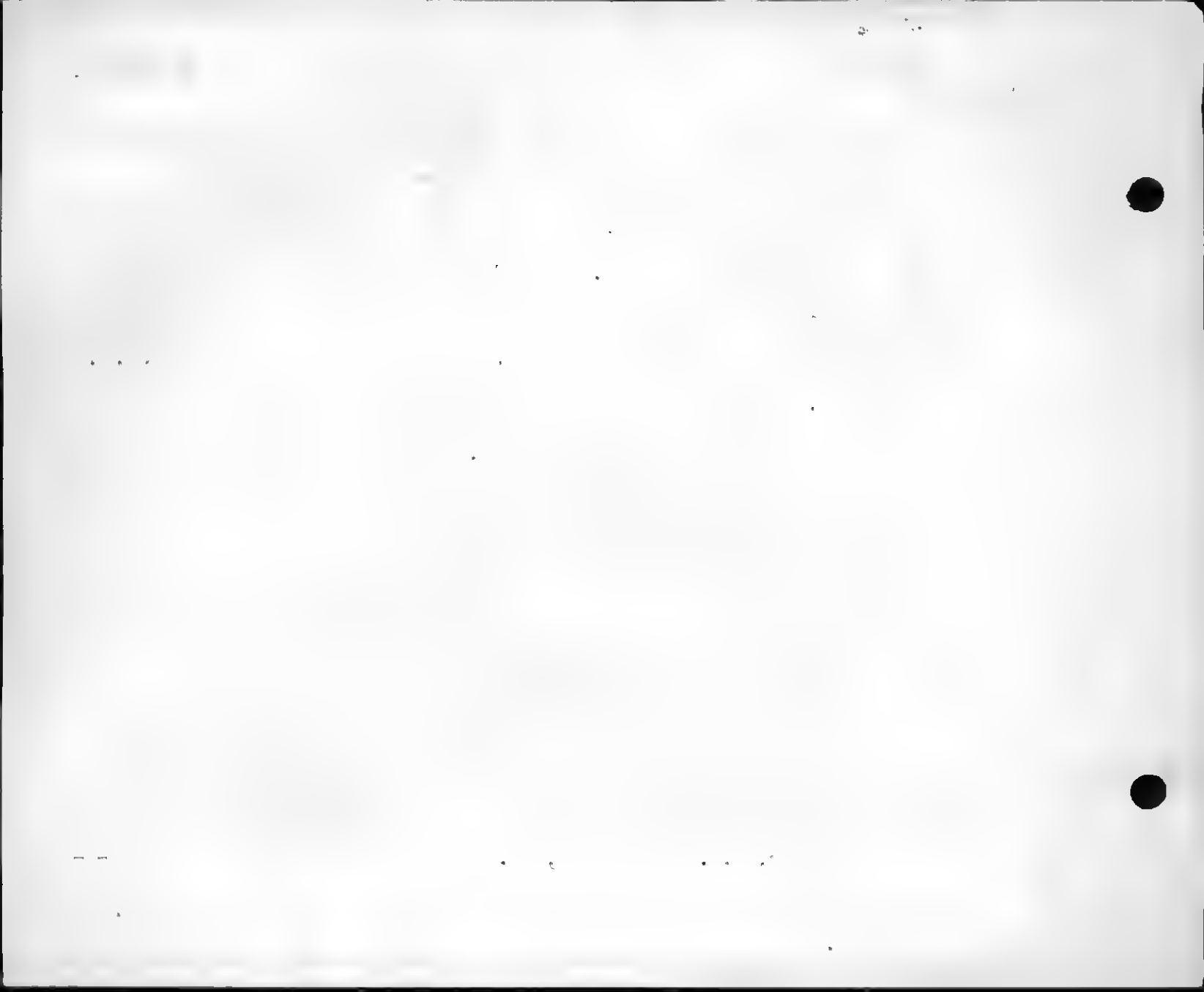
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04163

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04162

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward D. Thompson				4. DATE OF DEATH 3 7 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 March 1917	
9. AGE (In years lost birthday) 49 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Lee Fencing Co.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Ernest R. Thompson			
14. MOTHER'S MAIDEN NAME Iola C. Connor				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. -				17. INFORMANT Mrs. Dorothy Thompson (above address) Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH minutes unknown						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 3-7-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/67		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cem.		23d. LOCATION (City or town) (County) (State) Front Royal, Va.	
24. FUNERAL DIRECTOR Valley's Funeral Home Inc. Address Mt. Rainier, Maryland				25. REC'D BY REG. CLERK MAR 9 1967			
26. REG. CLERK'S SIGNATURE J. Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tobacco papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

74

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

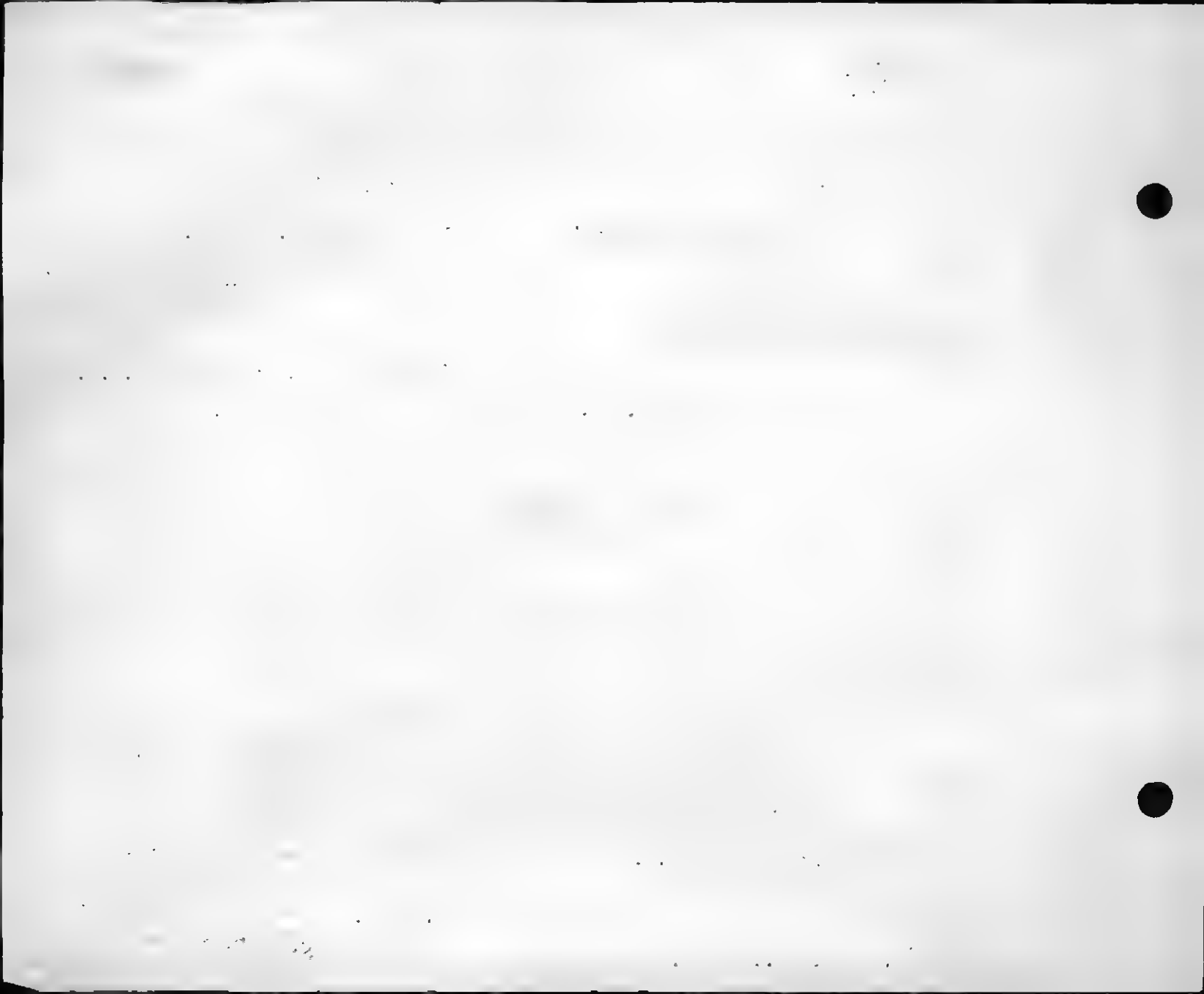
MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

05728

05728

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beaver Heights			
c. LENGTH OF STAY IN 1b 1 day				d. STREET ADDRESS 1413 52nd Ave. Apt. 302			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thornton				4. DATE OF DEATH March 22 19 67			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-67		9. AGE (In years lost birthday) yrs 22	10. IF UNDER 1 YEAR Months 2 IF UNDER 24 HRS. Days 2 Hours 67 Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland U.S.A.		12. "TIZEN OF WHAT COUNTRY?"
13. FATHER'S NAME Francis Elwood Thornton, Sr.				14. MOTHER'S MAIDEN NAME Grace Lorraine Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO		17. INFORMANT Mother Address As above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 716A IMMEDIATE CAUSE (a) Pneumonia (3.2 Pounds) DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-22-67 to 3-23-67 , that (I) (we) last saw the deceased alive on 3-23-67 and that death occurred at 4:50P M, from causes and on the date stated above.							
22a. SIGNATURE F. Kazemi			M.D. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/24/67		
22c. PHYSICIAN'S NAME (Type) Farizar Kazemi, M.D.			22d. ADDRESS Prince Georges General Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/8/67		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly		23d. LOCATION (City or Town) (County) (State) PG Maryland	
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland			25a. REC'D BY REGISTRAR APR 11 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		



FOR STATE
HEALTH DEPT.

04164

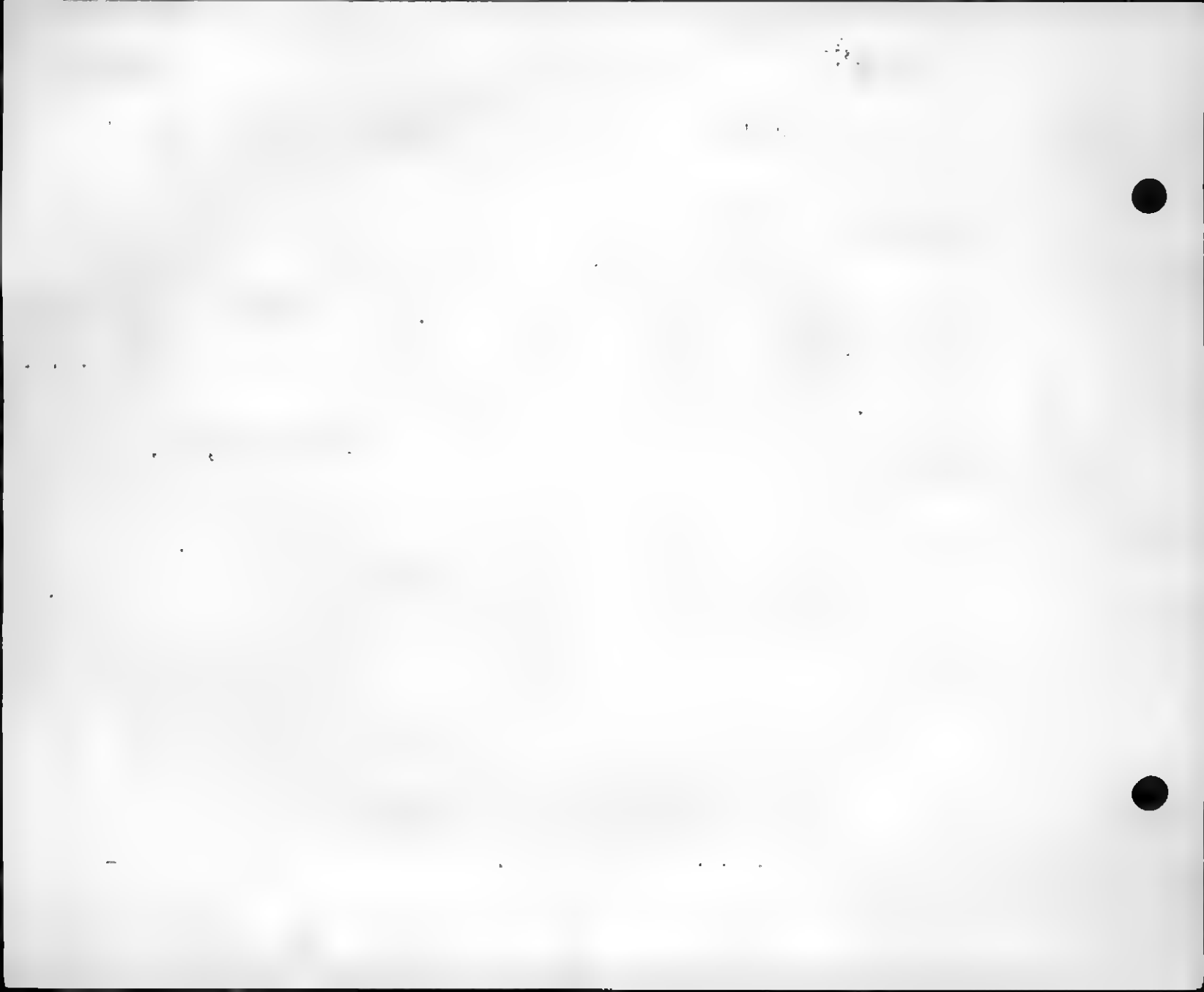
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04163

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN ID DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 803 Karen Court	
3 NAME OF DECEASED (Type or print) First Bernard Middle William Last Tracy		4 DATE OF DEATH Month 3 Day 16 Year 19 67	
5 SEX Male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 19 Aug. 1930
9 AGE (In years lost birthday) 36 yrs		10 IF UNDER 1 YEAR Months 3 Days 16 Hours 19 Min. 67	
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Loan Officer		10b. KIND OF BUSINESS OR INDUSTRY Citizen's Bank	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Edward B. Tracy		14 MOTHER'S MAIDEN NAME Margaret Farley	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 1952-1954		16 SOCIAL SECURITY NO. 1952-1954	
17 INFORMANT Edward Tracy-Livittown, Pa.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive subarachnoid and left internal capsular hemorrhage DUE TO minutes (b) And coronary artery occlusion, old and recent. DUE TO Hypertensive arteriosclerotic cardio vascular disease (c) unknown.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-16-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3-20-67	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl	23d. LOCATION (City or Town) (County) (State) Arlington Va
24. FUNERAL DIRECTOR Dr. Witt Danesedon		25. REC'D BY REGISTRAR MAR 27 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04165

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04164

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c LENGTH OF STAY IN b DOA			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home				d STREET ADDRESS 5514 Madison Street			
3 NAME OF DECEASED (Type or print) First Middle Last Loretta Doudiken Waddell				4 DATE OF DEATH Month Day Year 3 9 19 67			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 OF BIRTH 23 April 1912	9 AGE (In years last birthday) 55 yrs	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY?
13 FATHER'S NAME Edward F. Doudiken			14 MOTHER'S MAIDEN NAME Catherine Shipley				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None			16 SOCIAL SECURITY NO		17 INFORMANT Address Mr. Robert W. Waddell same address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9160 IMMEDIATE CAUSE (a) Burns - total body DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) Burned when bed caught fire.				
20c TIME OF INJURY Month, Day, Year Hour a.m. 12:10am 3-9- 19 67			20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) home		20f (City or town) (County) (State) same as #2
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
					Address (Street, city, town, or county) 3-9-67		
23a BURIAL CREMATION OR REMOVAL (Type) Burial		23b DATE THEREOF 3/13/1967		23c NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d LOCATION (City or town) (County) (State) Baltimore, Maryland	
24 FUNERAL DIRECTOR Wm J. Fisher & Sons				ADDRESS Baltimore, Md.		25a REC'D BY REGISTRAR MAR 13 1967	
						25b REGISTRAR'S SIGNATURE J Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04166

CERTIFICATE OF DEATH

04165

1. PLACE OF DEATH a. COUNTY <u>Prince George Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hughesville Md.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton Md.</u>		c. LENGTH OF STAY IN b. <u>Feb 5-67</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pineview Gardens Center</u>				d. STREET ADDRESS <u>Stuart Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Wade</u> Last <u>Wade</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>5</u> Year <u>1967</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-17-1885</u>	9. AGE (in years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Winnsboro S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Wikes</u>				14. MOTHER'S MAIDEN NAME <u>Phyllis Ellson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>519-03-9592</u>		17. INFORMANT <u>Martin L. McDowell</u> Address <u>Mechanicville Md. Rt. 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>203X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Metastatic Carcinoma</u> (c) <u>Multiple Myeloma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-5 days</u> <u>2-3 months</u> <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 5</u> , 19 <u>67</u> , to <u>March 5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 5</u> , 19 <u>67</u> , and that death occurred at <u>3:15</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>Alfred R. Lapin</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN MD</u>				22d. ADDRESS <u>CLINTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-8-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cath. Ch. Cem. Bryantown Chas. Co. Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Mantell Adams Aquasco, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

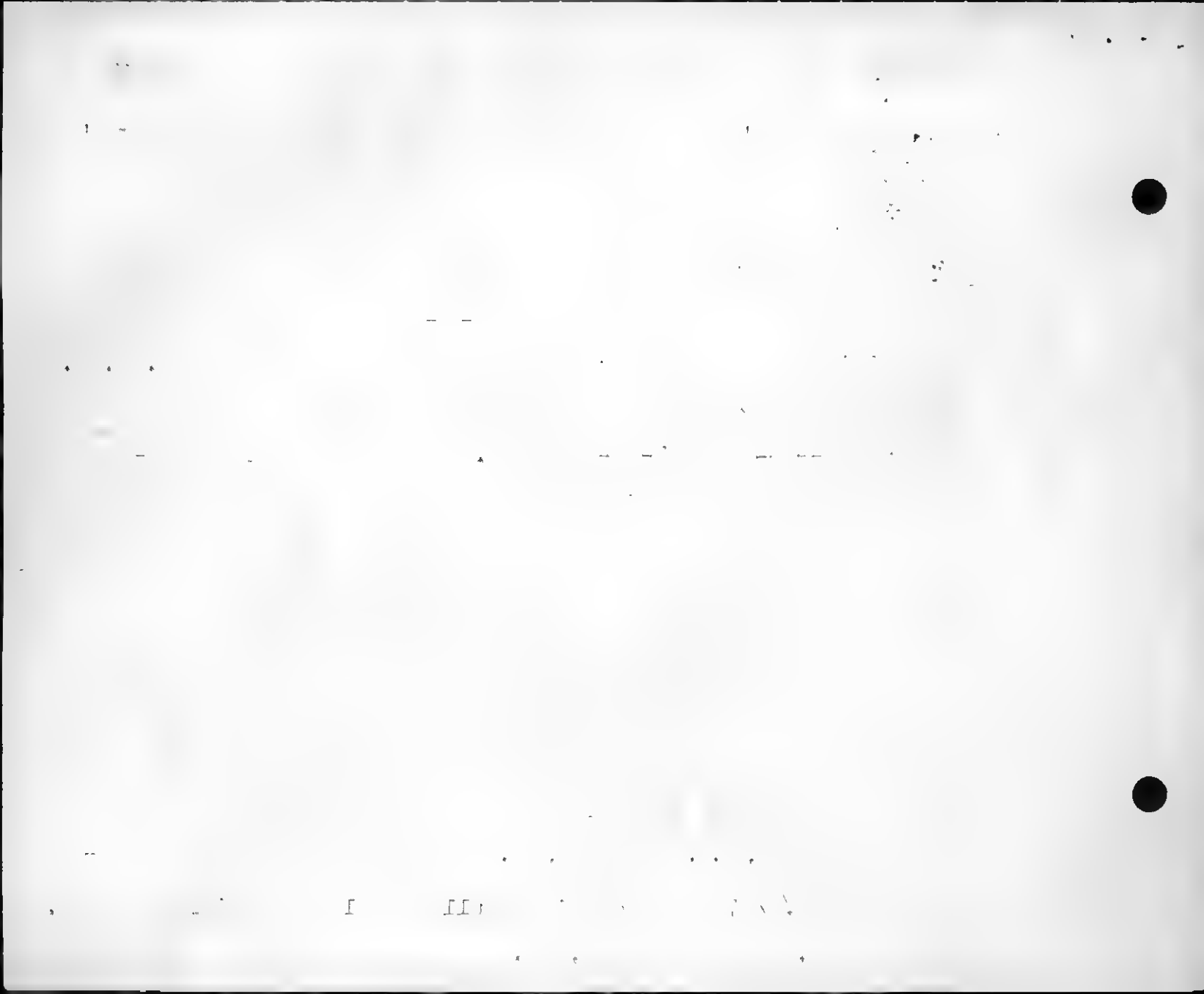
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04167 Items #10b & 15 Film #0286 3/15/67
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04166

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN b. DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside		d. STREET ADDRESS 5906 L Street
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last William Clarence Walton			4. DATE OF DEATH Month Day Year 3 6 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-12-1893	9. AGE (In years last birthday) 74 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Olin Scott Walton		
14. MOTHER'S MAIDEN NAME Sarah Silver			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown No		
16. SOCIAL SECURITY NO 577-05-5657			17. INFORMANT Mrs. Myrtle Virginia Walton- Item #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-7-67	
23a. BURIAL (CREMATION REMOVAL) (Type) Burial		23b. DATE THEREOF 3/9/67		23c. NAME OF CEMETERY OR CREMATORY Cedarville Full Gospel Cedarville Md.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAR 8 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE
HEALTH DEPT

04168

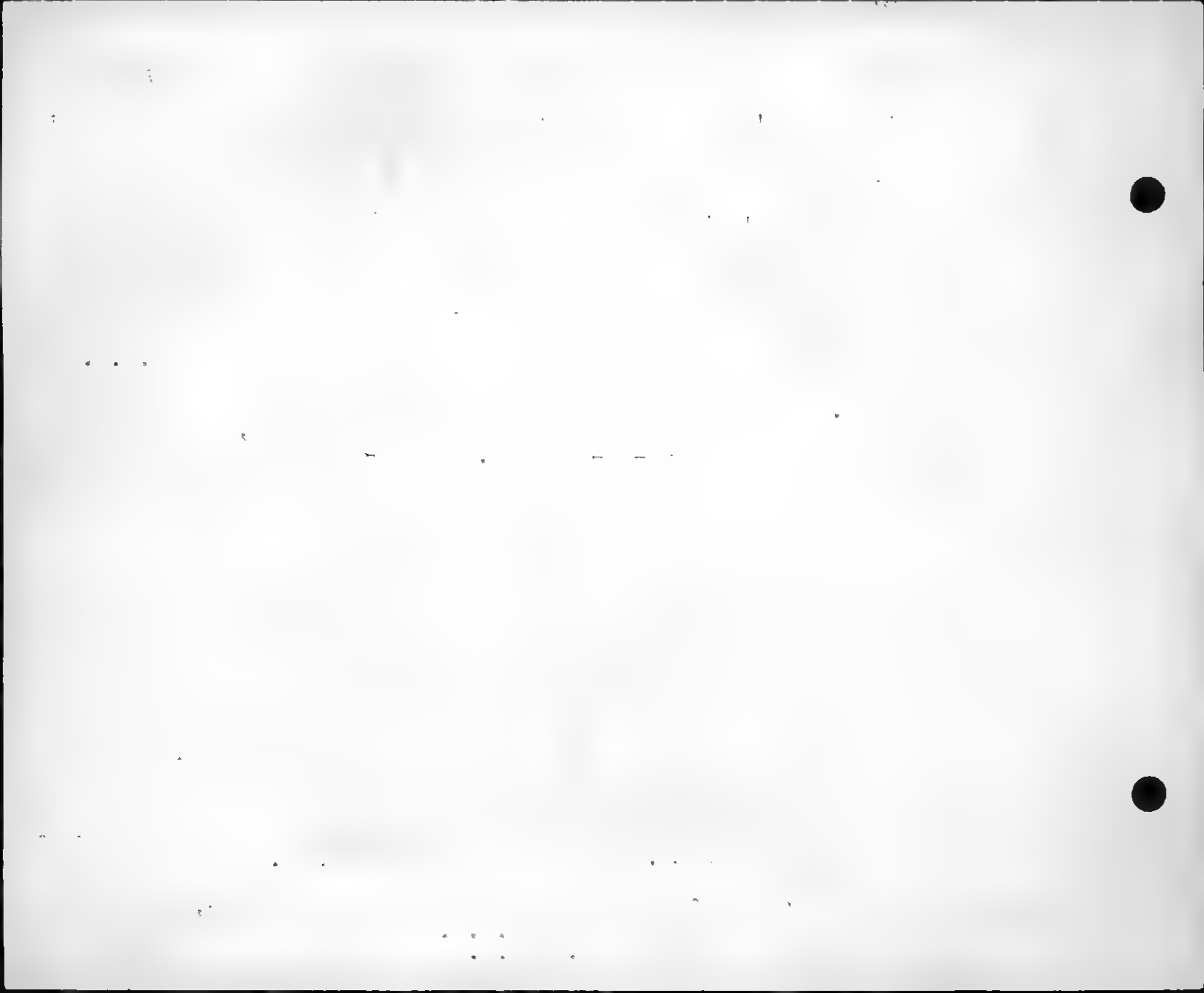
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04167

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN TB DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e STREET ADDRESS Box 61	
3 NAME OF DECEASED (Type or print) First Middle Last Robert James Warnke		4 DATE OF DEATH Month Day Year March 11 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 2-14-26
9 AGE (In years last birthday) 41 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST	
10b KIND OF BUSINESS OR INDUSTRY MACHINIST		11 BIRTHPLACE (State or foreign country) STATE OF NEW YORK	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME ERNEST W. WARNKE	
14 MOTHER'S MAIDEN NAME CATHALEEN POST		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNKNOWN	
16 SOCIAL SECURITY NO 069-24-9905		17 INFORMANT ELMSFORD, NEW YORK	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Delirium Tremens 7X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME Type John Kehoe, M.D.		22. DATE SIGNED 3-12-67	
23a BURIAL CREMATION, REMOVAL, SPOKE (Type)		23b DATE THEREOF 3/15/1967	
23c NAME OF CEMETERY OR CREMATORY MT. CALVARY CEMETERY		23d LOCATION (City or town) (County) (State) GREENBURG, NEW YORK	
24 FUNERAL DIRECTOR HYSONG'S FUNERAL HOME		25a RECEIVED BY REGISTRAR MAR 14 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

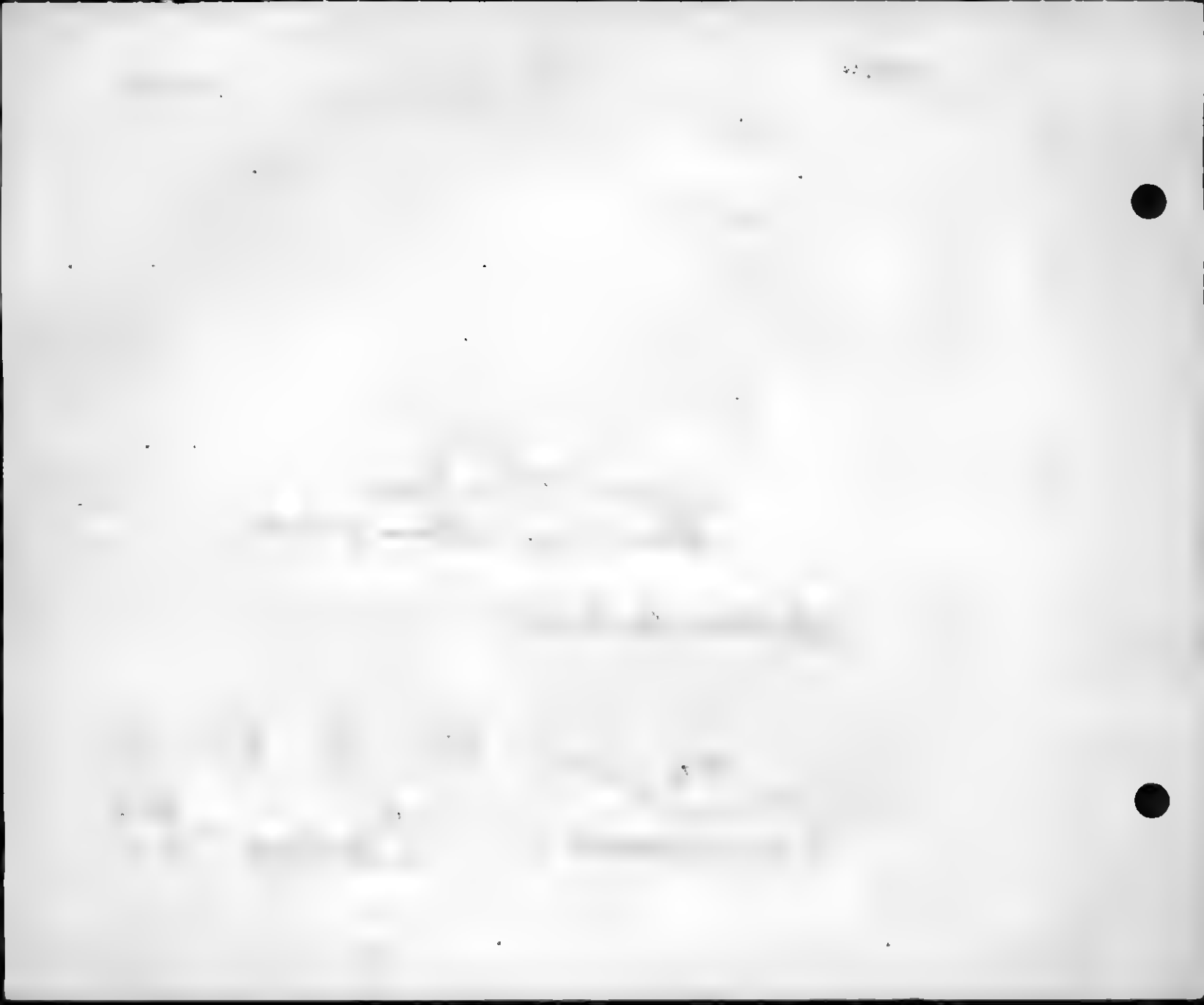
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04169

CERTIFICATE OF DEATH

04168

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pro George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Paint Branch Nursing Home		d. STREET ADDRESS 11128 Emack Road	
3. NAME OF DECEASED (Type or print) First Ethel Middle L Last Wells		4. DATE OF DEATH Month March Day 2 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 18, 1895
9. AGE (In years and birthday) 72 Yrs		10. IF UNDER 1 YEAR Months 2 Days 16 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Elliott		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Bernard L Wells		Address Beltsville, Md.	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 32X Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Generalized Arteriosclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 5 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stroke Myelitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3/2	20f. (City or town) (County) (State) 3/2 67
21. I certify that (I) (this hospital) attended the deceased from 3/2 , 19 67 to 3/2 , 19 67 , that (I) (we) last saw the deceased alive on 3/2 , 19 67 , and that death occurred at 5P M, from causes and on the date stated above.			
22a. SIGNATURE W.K. Etienne		22b. DATE SIGNED 3/3/67	
22c. PHYSICIAN'S NAME (Type) W.K. Etienne		22d. ADDRESS College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 6, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR DATE MAR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04170

CERTIFICATE OF DEATH

04169

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 6107 Queens chapel Rd.,	
3. NAME OF DECEASED (Type or print) First Middle Last Ruel S. Wheeler		4. DATE OF DEATH Month 3-21 Day Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-00
9. AGE (In years last birthday) yrs 66		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) installer		10b. KIND OF BUSINESS OR INDUSTRY Retired phone company	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Middleton Wheeler		14. MOTHER'S MAIDEN NAME Edna Mae Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Daughter & medical Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) GEN. ARTERIOSCLEROSIS DUE TO (c) UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIAL ASTHMA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'a m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-29-1948, to 3-21-1967, that (I) (we) last saw the deceased alive on 3-20-1967, and that death occurred at 6:21 AM, from causes and on the date stated above.			
22a. SIGNATURE C. J. Houmann		22b. DATE SIGNED 3-21-67	
22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.		22d. ADDRESS 4404 Queensbury Rd., Riverdale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-24-67	23c. NAME OF CEMETERY OR CREMATORY Meadowdale Mem	23d. LOCATION (City or Town) (County) (State) Darnest Md
24. FUNERAL DIRECTOR Dr. Witt Donaldson		25a. REC'D BY REGISTRAR MAR 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

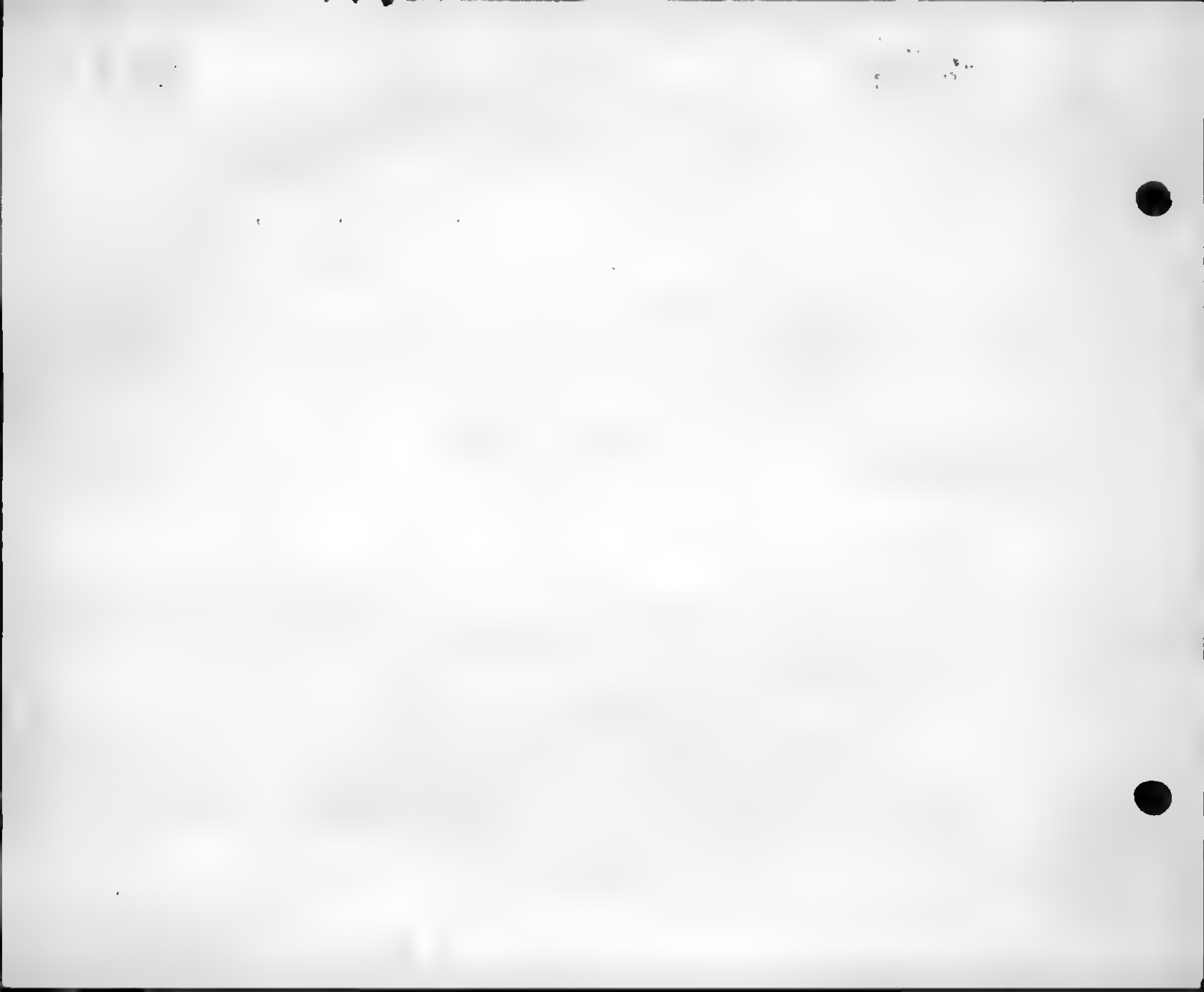
CERTIFICATE OF DEATH

04171

04170

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, Maryland</u> c. LENGTH OF STAY IN 1b <u>7 days, 4hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leland Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Maryland</u> d. STREET ADDRESS <u>Rt. 1, Box 200, Laurel, Maryland</u> e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert A. Whisner</u>			4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/15/1882</u>		9. AGE (In years last birthday) yrs <u>84</u> IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Columbus Ohio</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>unknown</u>				
14. MOTHER'S MAIDEN NAME <u>unknown</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>				
16. SOCIAL SECURITY NO. <u>298-05-5521</u>			17. INFORMANT <u>Records</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Myocardial Infarction</u> DUE TO (b) <u>Compensated Heart Failure</u> DUE TO (c) <u>Compensated Heart Block</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u> </u> to <u>3/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert Wingfield</u>			22b. DATE SIGNED <u>3/8/67</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT WINGFIELD</u>		
22d. ADDRESS <u>Laurel Md</u>			22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 9, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodland Park</u>			
23d. LOCATION (City or Town) <u>Dayton Ohio</u>		23e. (County) <u> </u>		23f. (State) <u> </u>			
24. FUNERAL DIRECTOR <u>De Witt Canadian, Laurel Md</u>			25a. REC'D BY REGISTRAR <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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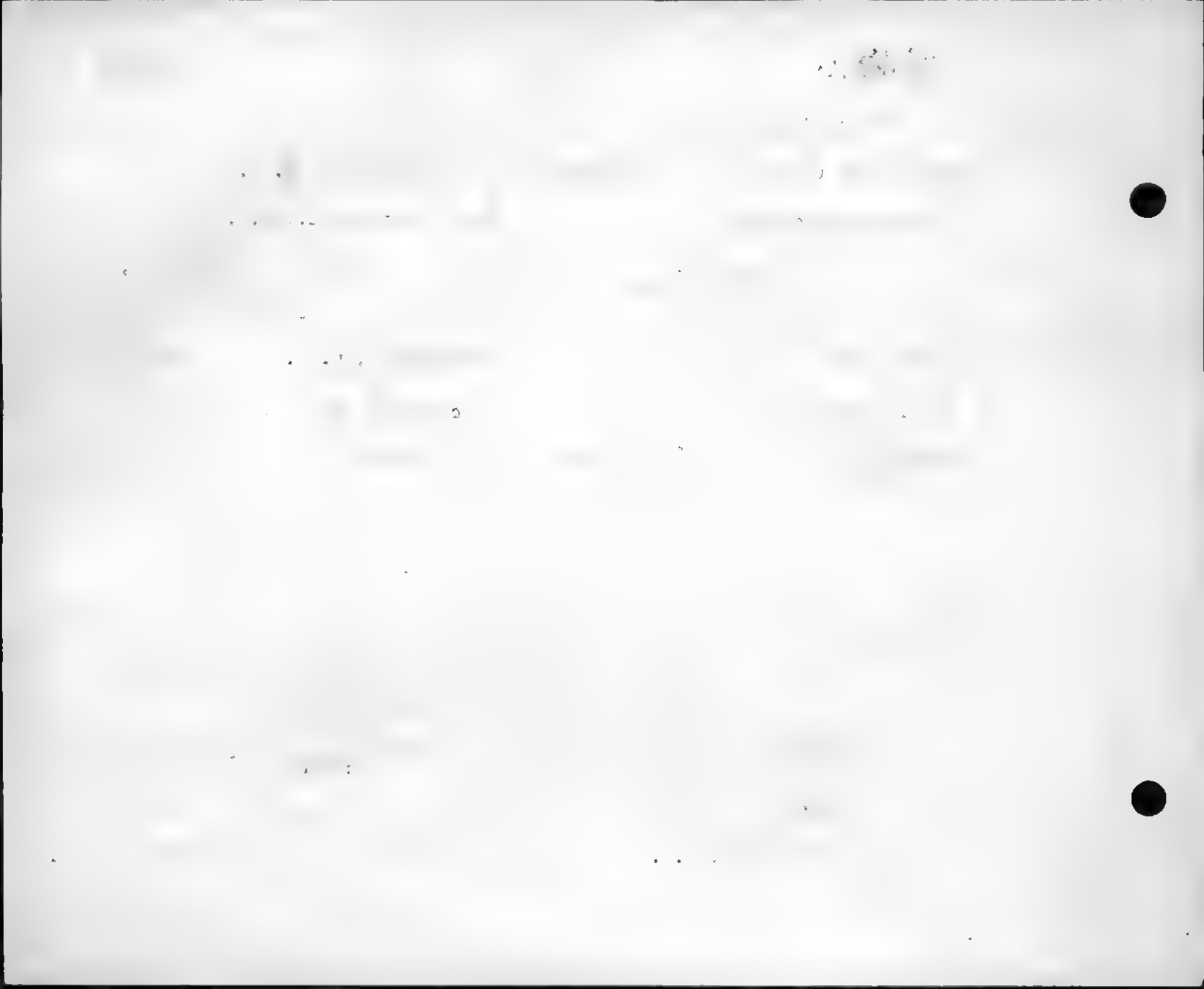
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04172

CERTIFICATE OF DEATH

04171

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE _____ b. COUNTY _____				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)			c. LENGTH OF STAY IN 1b 5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 4427 Quarles St., N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Howard H. Middle White Last _____				4. DATE OF DEATH Month March Day 9 Year 19 67				
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/15/34		
9. AGE (In years last birthday) 32 yrs		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 24 HRS Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fence man				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		
12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME William White				14. MOTHER'S MAIDEN NAME Cordelia White ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO 225-34-0460		17. INFORMANT decadent Address _____				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute adrenal insufficiency DUE TO (b) Acute hemorrhagic necrosis of the adrenals DUE TO (c) Acute renal tubular necrosis: status post left upper lobectomy (2/27/67)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/29/ 19 66 , to 3/9/ 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/9/ 19 67 , and that death occurred at 7:00AM from causes and on the date stated above.								
22a. SIGNATURE Moe Weiss				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/9/67		
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-15-1967		23c. NAME OF CEMETERY OR CREMATORY HARMONY		23d. LOCATION (City or Town) (County) (State) LANDOVER MARYLAND		
24. FUNERAL DIRECTOR Tarvis Funeral Home				ADDRESS 14 W. U. St. h		25a. REC'D BY REGISTRAR 14 1967		
				25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

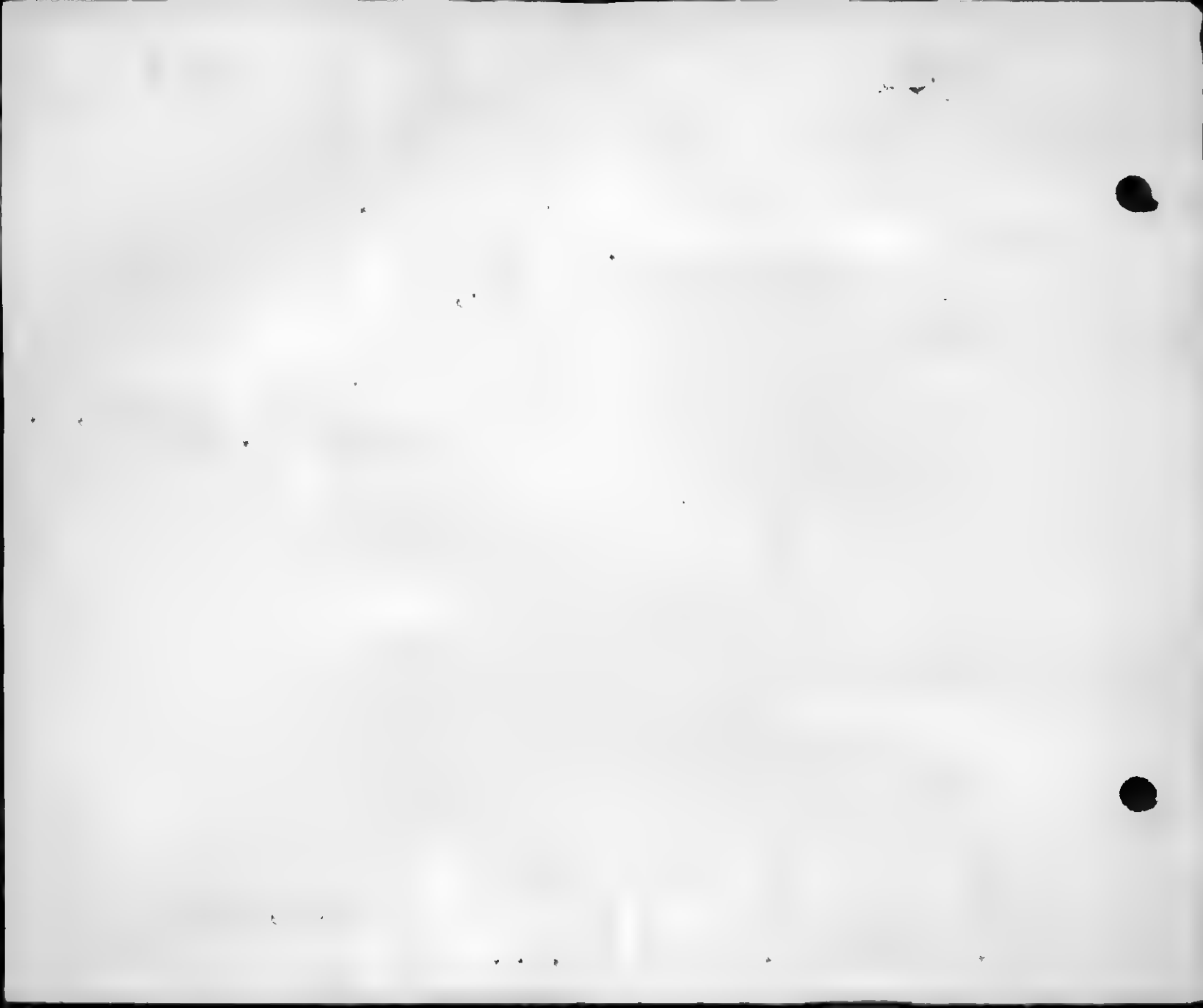
CERTIFICATE OF DEATH

04173

04172

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George County General Hosp.		d. STREET ADDRESS 1413 58th. Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Daisy Middle A. Last Williams		4. DATE OF DEATH Month 3 Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1888
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min 15	11. IF UNDER 24 HRS. Months 7 Days 15 Hours 15 Min 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Alabama	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Allen		14. MOTHER'S MAIDEN NAME Lula Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Prince Williams		Address: Chapel Oaks, Md. 1413 58th. Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Heart Disease - Congestive Heart Failure DUE TO (b) Hypertension and Atherosclerosis DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1967			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 18, 1967 to present , 19____, that (I) (we) last saw the deceased alive on 3-8-1967 , and that death occurred at 7:15 A.M. from the causes and on the date stated above			
22a. SIGNATURE Charles S Ireland MD		22b. DATE SIGNED 3-15-67	
22c. PHYSICIAN'S NAME (Type) Charles S IRELAND MD		22d. ADDRESS 1240 R.I. Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/18/1967	23c. NAME OF CEMETERY OR CREMATORY Harmony	23d. LOCATION (City town, or county) (State) Landover, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarvis Co.		25a. REC'D BY REGISTRAR 20 MAR 20 1967	
ADDRESS 1132 You Street, N.W.		25b. REG STRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item # 7 Film # 33-7 47367-56

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04174

04173

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE Indiana WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY N to 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Box #430	
3 NAME OF DECEASED (Type or print) First Middle Last Edward Everett Williams		4 DATE OF DEATH Month Day Year 3 26 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-19-10
9 AGE (In years last birthday) 56 yrs		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer		10b. KIND OF BUSINESS OR INDUSTRY Garments	
11 BIRTHPLACE (State or foreign country) Indiana		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elmer T. Williams		14. MOTHER'S MAIDEN NAME Bertha Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert Williams		Address 1935 Brook Drive Hillside Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4200 DUE TO Conditions, (b) which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-26-67	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		Address (Street, city, town or county) Salem, Ind.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Mar. 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Crown Hill	23d. LOCATION (City or Town) (County) (State) Salem, Ind.
24. FUNERAL DIRECTOR Robert E. Wilhelm Robert E. Wilhelm		25a. REC'D BY REGISTRAR MAR 30 1967	
ADDRESS 4308 Suitland Rd. Suitland Md.		25b. REGISTRAR'S SIGNATURE John Charles Judge	



20



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VP A15ME (5)
6M 1/67

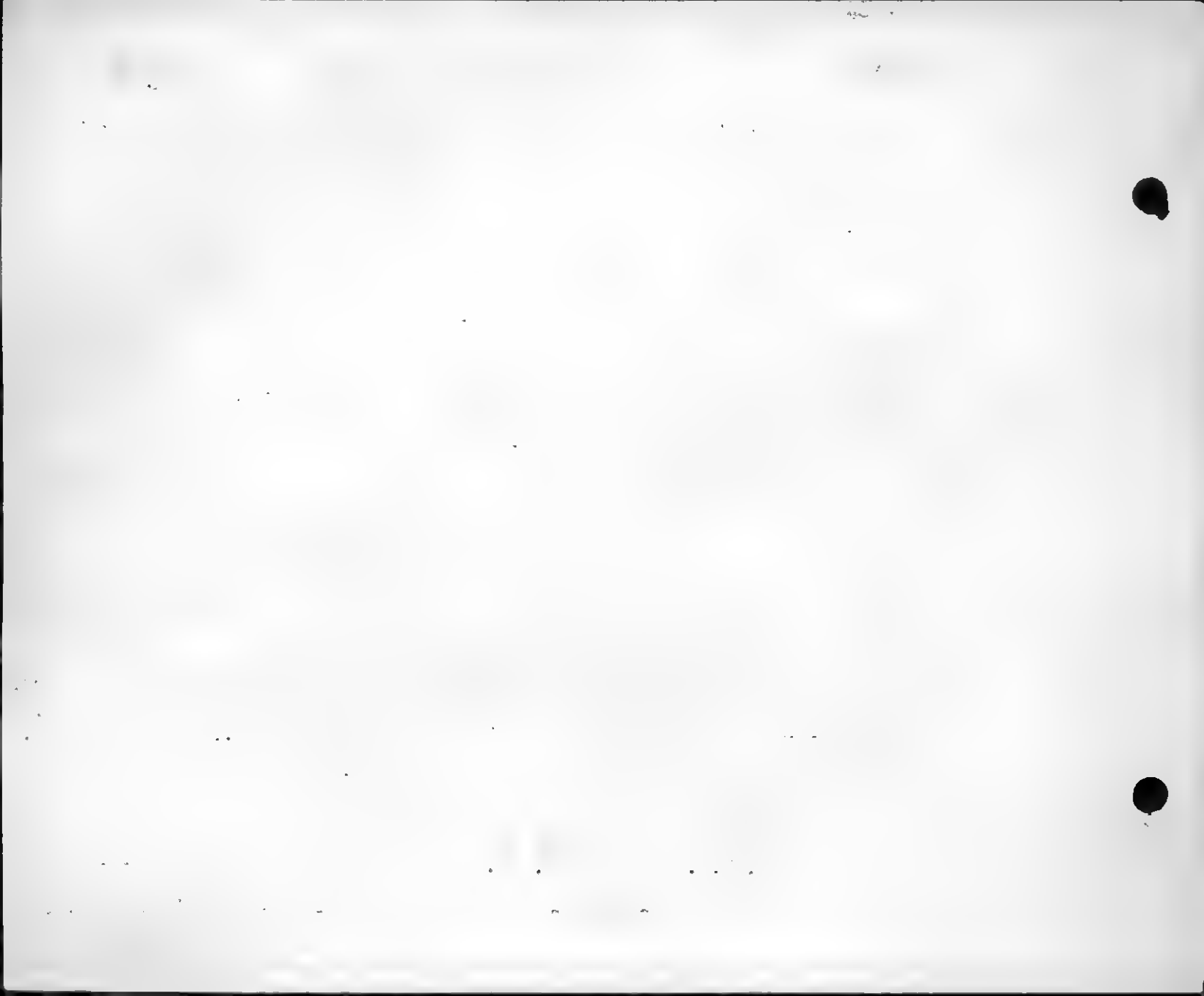
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04175

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04174

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Parking lot of 3206 Curtis Drive		d. STREET ADDRESS 6314 Kennedy Street	
3. NAME OF DECEASED (Type or print) First Middle Last Huey Kyle Wilson		4. DATE OF DEATH Month Day Year 3 1 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-1935
9. AGE (In years last birthday) 31 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 1 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD		10b. KIND OF BUSINESS OR INDUSTRY NAT. SECURITY GUARD	
11. BIRTHPLACE (State or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME CHARLES WILSON		14. MOTHER'S MAIDEN NAME OLLIE B. PEEKS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) KOREAN YES KOREAN		16. SOCIAL SECURITY NO 409 48 4383	
17. INFORMANT KATHYLEEN WILSON		Address SAME AS 2 ABCD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 983X IMMEDIATE CAUSE (a) Asphyxia DUE TO Aspiration of gastric contents (b) Secondary to multiple rib fractures DUE TO From trauma (c)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) ant Vomited and aspirated in association with attack by assailant	
20c. TIME OF INJURY Month Day Year between 12:00am 3-1- 1967		20d. INJURY OCCURRED Where <input checked="" type="checkbox"/> Not Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Parking lot 3206 Curtis Dr., Hillcrest Hgts.		20f. (City or town) (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-2-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL	23b. DATE THEREOF 6 MAR. 1967	23c. NAME OF CEMETERY OR CREMATOR HAPPY VALLEY MEM PK	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD		23d. LOCATION (City or town) (County) (State) ELIZABETHTON TENN	
DATE MAR 8 1967		REGISTRAR'S SIGNATURE John Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04176

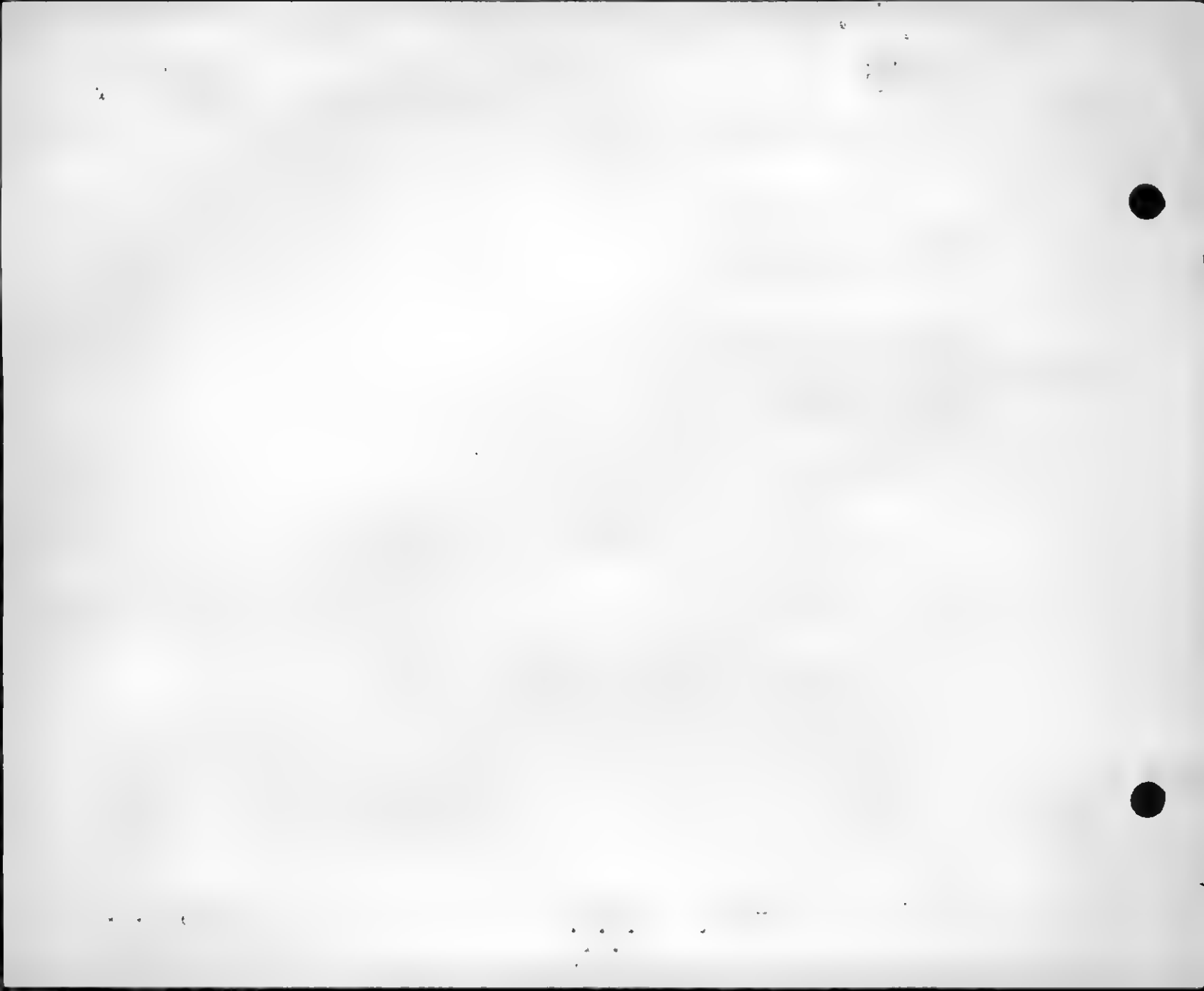
CERTIFICATE OF DEATH

04175

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admision) a. STATE <u>D.C.</u> b. COUNTY <u>-</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. LENGTH OF STAY IN 15 <u>4 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>473</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u>			d. STREET ADDRESS <u>612 Fern Place N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha</u> <u>Blanche</u> <u>Wineberger</u>			4. DATE OF DEATH Month Day Year <u>March</u> <u>5</u> <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/12/77</u>	9. AGE (in years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>	
13. FATHER'S NAME <u>Henry Yost, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Caroline Brandt</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-60-1395</u>		17. INFORMANT Address <u>Daughter - 612 Fern Place N.W. Washington, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremic coma</u> DUE TO (b) <u>nephrosclerosis and bilateral pyelonephritis</u> DUE TO (c) <u>9 mo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>a series of cerebral vascular accidents</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15</u> , 19 <u>66</u> , to <u>3/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/4</u> , 19 <u>67</u> , and that death occurred <u>at 4</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>D.B. Washington</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>D.B. Washington MD</u>		22d. ADDRESS <u>5802 Ridgefield Rd Bethesda 14 Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-7-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>JOSEPH AUGER'S SONS INC</u>		25a. REC'D BY REGISTRAR <u>MAR 9 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

04177

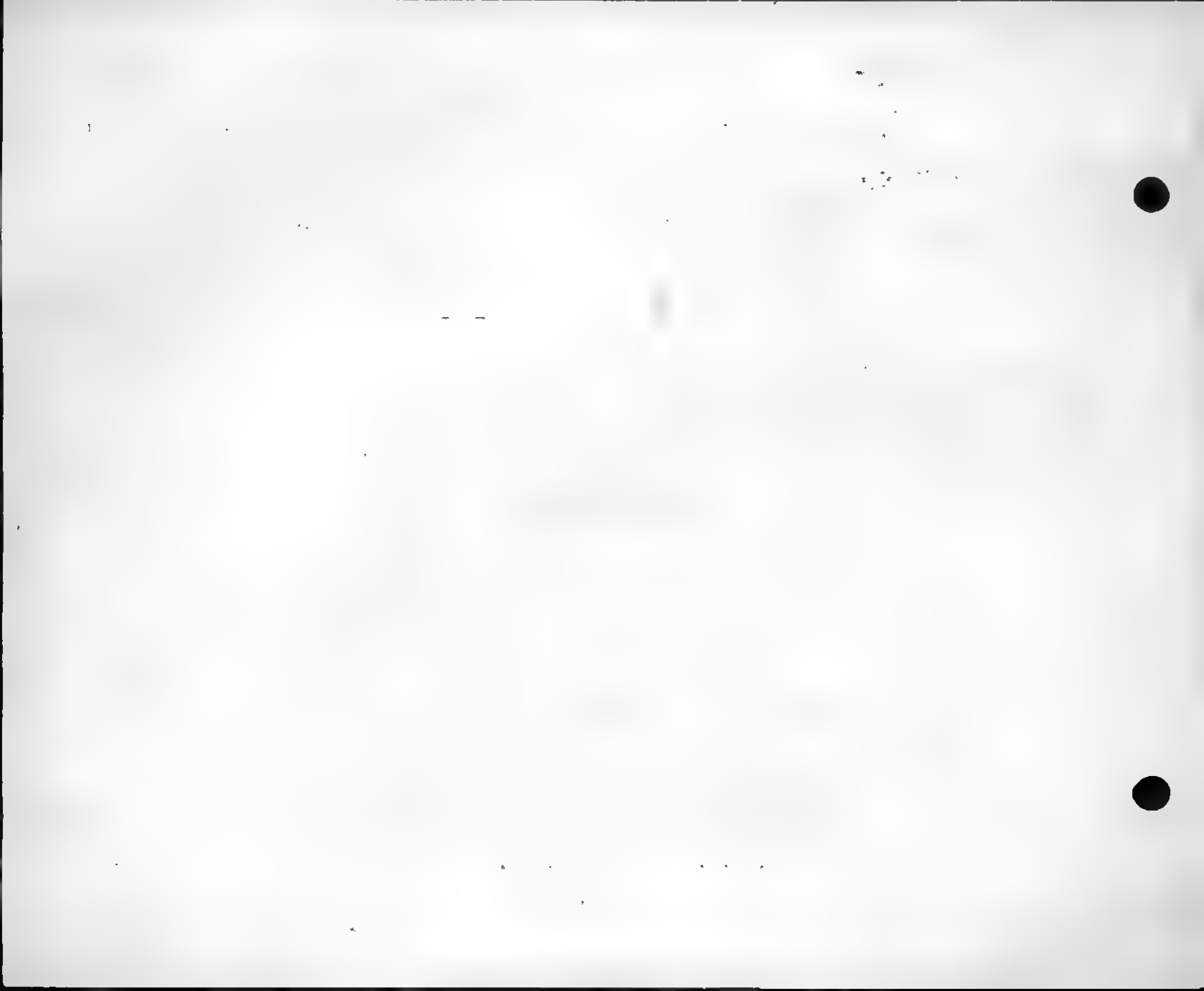
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04176

1 PLACE OF DEATH a. COUNTY Prince George's		2 USUAL RESIDENCE (Where deceased lived, if institution. Reside before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY N 16 DOA	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Foster		4 DATE OF DEATH Month 3 Day 22 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF B. H. 12-13-1895
9 AGE (In years last birthday) 71 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Md	
13. FATHER'S NAME Court Foster Wood		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17. INFORMANT Grace Wood.		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes over 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 3-22-67	
23a BURIAL CREMATION OR REMOVAL (Specify) Cremation		23b DATE THEREOF 3.24.67	
23c NAME OF FEMTORY OR CREMATORY Lee's Crematory		23d LOCATION (City or Town) (County) (State) Washington D C	
24 FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E		25a REC'D BY REGISTRAR MAR 27 1967	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

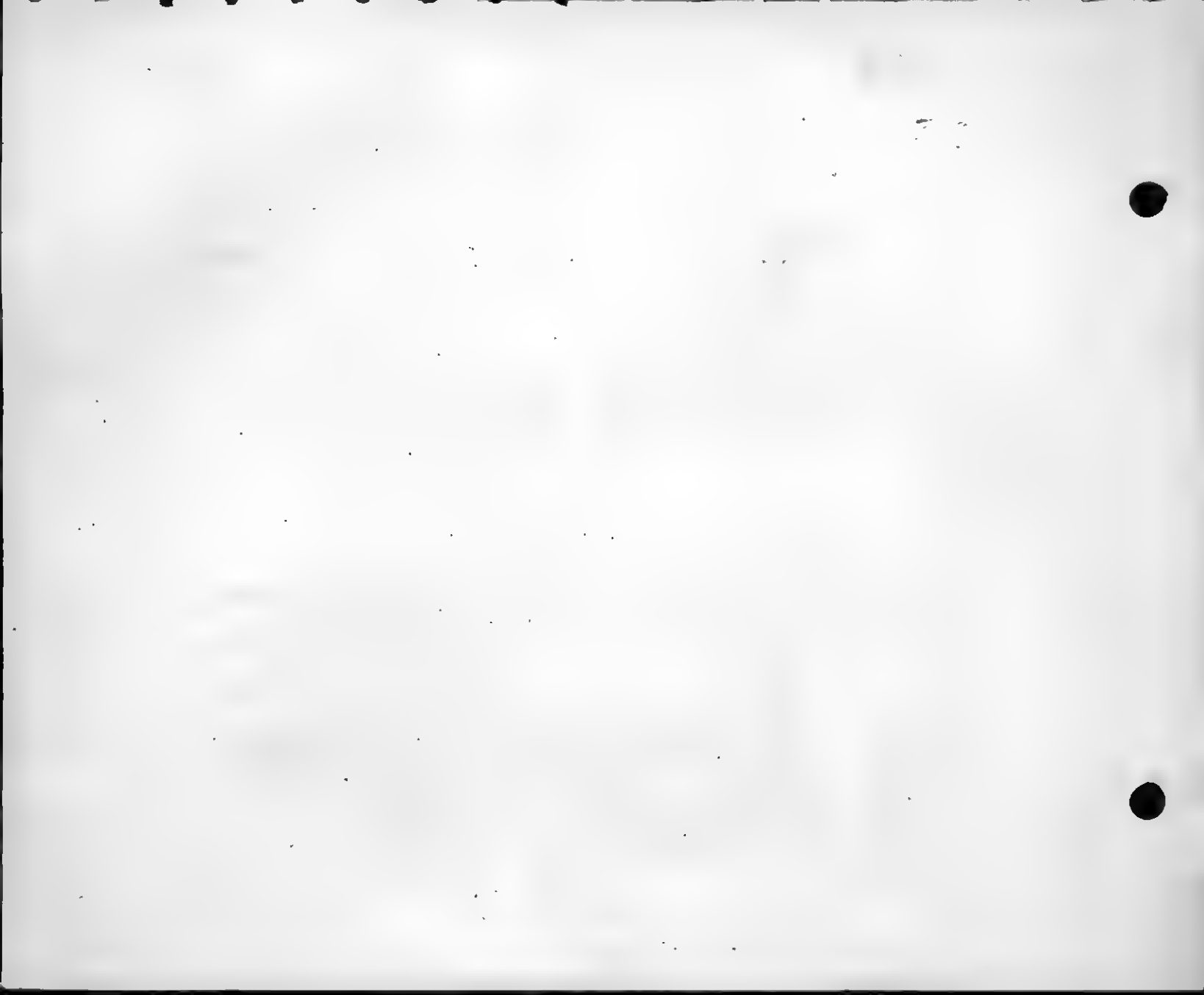
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04178

CERTIFICATE OF DEATH

04177

1. PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheney</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Geo. General</u>		d. STREET ADDRESS <u>4538 Eastern Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>KEE</u> Last <u>WOOD</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/04</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab driver</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Taxi</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Seat Pleasant, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Everett Wood.</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Schultz.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Philip Wood - 4538 Eastern Lane</u>		Address <u>Suitland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart Disease with Failure</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary Emphysema + Fibrosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1960</u> to <u>April 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 16, 1967</u> , and that death occurred at <u>7:44</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William Brainin</u>		22b. DATE SIGNED <u>3/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		22d. ADDRESS <u>6124 Central Ave, Capital Hill Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Addison Chapel Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
4308 Suitland Rd. Suitland, Maryland		DATE <u>MAR 20 1967</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

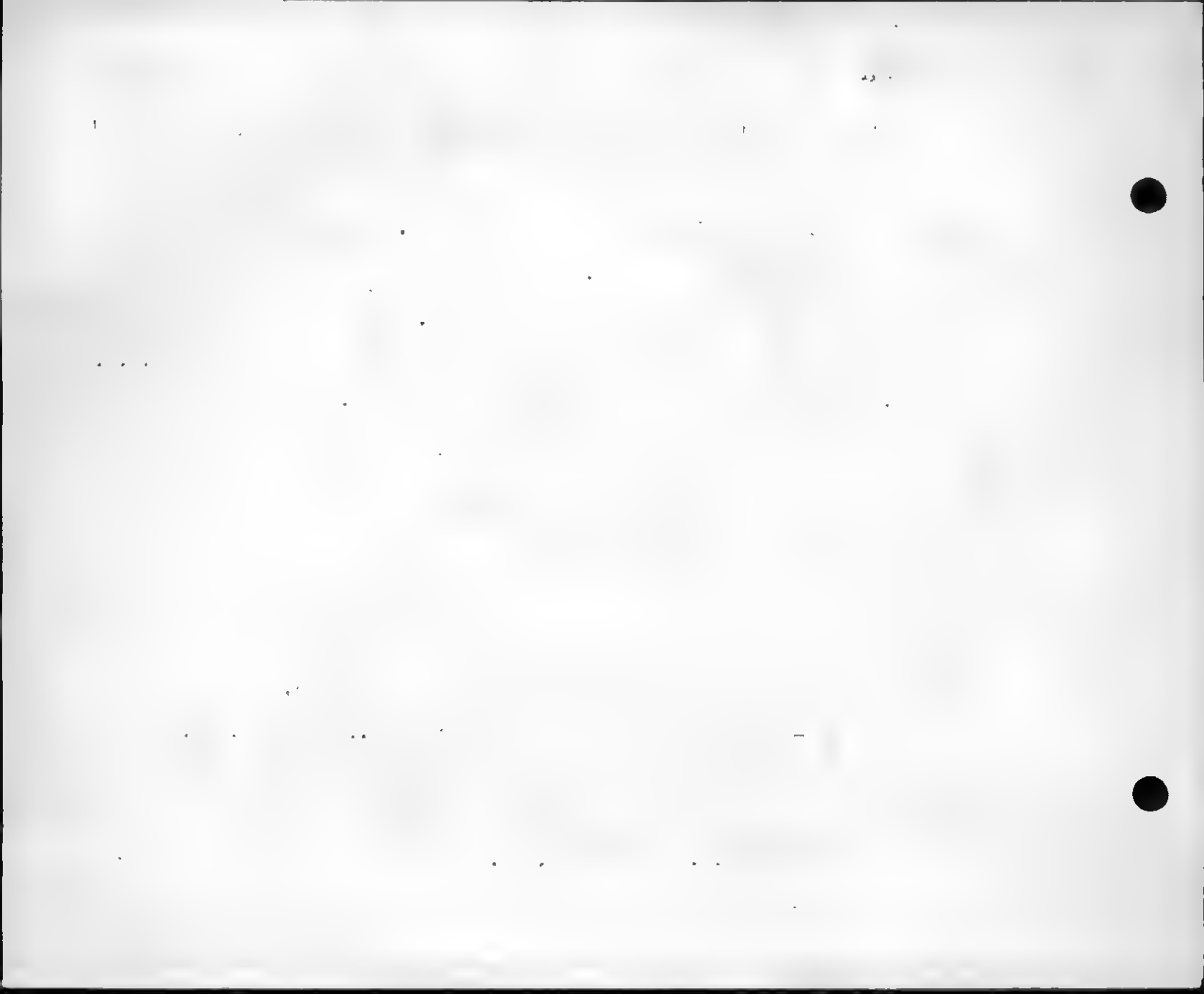
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04179		04178	
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 5803 M. Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roger Middle S. Last Wood		4. DATE OF DEATH Month 3 Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Oct. 1912
9. AGE (In years last birthday) 54 59's		10. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	
10b. KIND OF BUSINESS OR IND. STRY Giant Food Stores		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John E. Wood	
14. MOTHER'S MAIDEN NAME Gertrude E. Schultz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Pearl M. Wood Address 5803 M St Hillside Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lacerations of brain DUE TO Multiple fractures of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Arm of fork lift truck fell on head.	
20c. TIME OF INJURY Month Day, Year Hour a.m. 11:00pm 3-6-1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 6900 Sheriff Rd., Landover, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 3-7-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-9-1967	
23c. NAME OF CEMETERY OR CREMATORY Addison Chapel Cemetery		23d. LOCATION City or Town (County) (State) Seat Pleasant Maryland	
24. FUNERAL DIRECTOR Wilhelm Funeral Home Address 4308 Suitland Road Suitland Maryland		25a. REC'D BY REGISTRAR MAR 10 1967 25b. REGISTRAR'S SIGNATURE f Charles Judge	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04179

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
c. LENGTH OF STAY IN IB DOA		d. STREET ADDRESS 6401 Greig Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle DeSalles Last Woods		4. DATE OF DEATH Month 3 Day 30 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 July 1925
9. AGE (In years lost birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 3 Days 30 Hours 19 Min. 67	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Woods	
14. MOTHER'S MAIDEN NAME Marie Canty		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) WW II 43 to 46	
16. SOCIAL SECURITY NO. 220-16-5787		17. INFORMANT Betty Louise Woods - Seat Pleasant, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonites DUE TO Perforation of duodenal ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Recurrent duodenal ulcer DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH hours hours over 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 3-31-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4/3/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. SIGNATURE OF REGISTRAR Charles Judge		25a. REC'D BY REGISTRAR APR 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

07:20

07:20

Letter to the Editor

Dear Sir,

I am writing to you regarding the matter of the

letter which you received from me on the 15th

of the month of June last.

I am sorry to hear that you have not

yet received the letter which I wrote to you

on the 15th of June last.

I am sure that you will be able to

find the letter which I wrote to you

on the 15th of June last.

I am sure that you will be able to

find the letter which I wrote to you

on the 15th of June last.

I am sure that you will be able to

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04181		04180	
1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Magnolia Gardens Nursing Home</i>		d. STREET ADDRESS <i>8627 Park Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>James Bethuel Woods</i>		4. DATE OF DEATH Month <i>March</i> Day <i>30</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 20, 1880</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. U.S. Government Farm</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	9. AGE (In years last birthday) <i>87</i> yrs.
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel F. Woods</i>		14. MOTHER'S MAIDEN NAME <i>Unkn.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>William C. Woods</i>		8605 <i>Park Ave</i> <i>Bowie, Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Central thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>332X</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 13</i> , 19 <i>67</i> , to <i>3/30/67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/30</i> , 19 <i>67</i> , and that death occurred at <i>12:45 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. L. L. Lewis</i>		22b. DATE SIGNED <i>3/30/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Leon R. Levitsky</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE THEREOF <i>4/3/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>	23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor P.G. Md.</i>
24. FUNERAL DIRECTOR: <i>Sachs' Funeral Home, Hyattsville, Md</i>		25a. REC'D BY REGISTRAR <i>APR 3 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

08120

RECEIVED BY SHERIFF

18120

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